DOCUMENT RESUME

ED 327 639 CE 056 507

AUTHOR	Engel, Charles E.; And Others
TITLE	Continuing Education for Change. WHO Regional Publications, European Series, No. 28.
INSTITUTION	World Health Organization, Copenhagen (Denmark). Regional Office for Europe.
REPORT NO	ISBN-92-890-1119-X; ISSN-0378-2255
PUB DATE	90
NOTE	104p.
AVAILABLE FROM	World Health Organization Publications Center USA, 49 Sheridan Avenue, Albany, NY 12210.
PUB TYPE	Reports - Descriptive (141)
EDRS PRICE	MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	Allied Health Occupations Education; *Allied Health Personnel; *Continuing Education; Developed Nations; *Educational Change; Educational Needs; Foreign Countries; *Futures (of Society); Health Education; Postsecondary Education; *Primary Health Care; Professional Education
IDENTIFIERS	*Europe; *World Health Organization

ABSTRACT

This book presents an overview of the World Health Organization's implementation of continuing education for change in health care in Europe over the past 10 years. The report is organized in six sections. The introductory section asserts the need for change in health care and the rationale for providing continuing education for health care workers in order to effect such changes. Section 2 focuses on planning, implementing, evaluating, and organizing continuing education for change. In Section 3, the present state of continuing education in Europe is outlined, with emphasis on primary health care. It also examines the aims and methods of the country reports and case studies that follow in later sections. The fourth section suggests ways that continuing education can be more effective and more accountable in the future. Sections 5 and 6 present 19 country reports and 10 case studies of continuing education, especially in primary health care, in 1986-87 in European countries. Reasons for the studies are also examined. Appendixes to the report include a list of the country and case study reports and background papers, a 61-item bibliography on continuing education, and a glossary. (KC)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

World Health Organization
Regional Office for Europe
Copenhagen

ED327630

Continuing education for change

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

- Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL IN **MICROFICHE ONLY** HAS BEEN GRANTED BY

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

CE 056 507

WHO Regional Publications, European Series No. 28

The World Health Organization is a specialized agency of the United Nations with primary responsibility for international health matters and public health. Through this Organization, which was created in 1948, the health professions of some 165 countries exchange their knowledge and experience with the aim of making possible the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.

The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health problems of the countries it serves. The European Region has 32 active Member States,[a] and is unique in that a large proportion of them are industrialized countries with highly advanced medical services. The European programme therefore differs from those of other regions in concentrating on the problems associated with industrial society. In its strategy for attaining the goal of "health for all by the year 2000" the Regional Office is arranging its activities in three main areas: promotion of lifestyles conducive to health; reduction of preventable conditions; and provision of care that is adequate, accessible and acceptable to all.

The Region is also characterized by the large number of languages spoken by its peoples and the resulting difficulties in disseminating information to all who may need it. The Regional Office publishes in four languages — English, French, German and Russian — and applications for rights of translation into other languages are most welcome.

---

[a] Albania, Austria, Belgium, Bulgaria, Czechoslovakia, Denmark, Finland, France, German Democratic Republic, Federal Republic of Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Luxembourg, Malta, Monaco, Netherlands, Norway, Poland, Portugal, Romania, San Marino, Spain, Sweden, Switzerland, Turkey, USSR, United Kingdom and Yugoslavia.

Continuing education for change

WHO Library Cataloguing in Publication Data

Engel, Charles E.
Continuing education for change

(WHO regional publications. European series ; No.28)

1.Education, medical, continuing — trends 2.Health for all
3.Europe I.Vysohlid, Josef II.Vodoratski, Victor A.
III.Title IV.Series

ISBN 92 890 1119 X (NLM Classification W 20)
ISSN 0378-2255

World Health Organization
Regional Office for Europe
Copenhagen

Continuing education for change

Charles E. Engel
Emeritus Professor
Wellcome Tropical Institute
London, United Kingdom

Josef Vysohlid
Head, Department of Postgraduate Education
Institute for Postgraduate Education in Medicine and Pharmacy
Prague, Czechoslovakia

Victor A. Vodoratski
Former Regional Officer for Health Manpower Development (Education)
WHO Regional Office for Europe
Copenhagen, Denmark

WHO Regional Publications, European Series, No. 28

EUR/ICP/HMD 120

ISBN 92 890 1119 X
ISSN 0378-2255

© World Health Organization 1990

Publications of the World Health Organization enjoy copyright protection in accordance with the provisions of Protocol 2 of the Universal Copyright Convention. For rights of reproduction or translation, in part or *in toto*, of publications issued by the WHO Regional Office for Europe applications should be made to the Regional Office for Europe, Scherfigsvej 8, DK-2100 Copenhagen Ø, Denmark. The Regional Office welcomes such applications.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the Secretariat of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. The names of countries or areas used in this publication are those that obtained at the time the original language edition of the book was prepared.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

The views expressed in this publication are those of the authors and do not necessarily represent the decisions or the stated policy of the World Health Organization.

PRINTED IN DENMARK

Contents

Page

Acknowledgements vii

Foreword xiii

1. Introduction 1

2. Planning, implementing, evaluating and organizing continuing education for change 5
   The purpose of continuing education 5
   Planning a continuing education programme 8
   Implementing a continuing education programme 11
   Evaluating a continuing education programme 14
   Organizing continuing education for change 16
   Conclusion 18

3. The present state of continuing education in Europe, with emphasis on primary health care 19
   Country reports: insights and observations 19
   Case study reports: some observations and conclusions 31

4. Towards the future 35

5. Summaries of the country reports 39

6. Summaries of the case studies 65

Annex 1. Country and case study reports and background papers 81

Annex 2. Select bibliography on continuing education 85

Annex 3. Glossary 91

Acknowledgements

The authors wish to acknowledge everyone who has contributed to the numerous discussions, background papers, reports of meetings, country reports and case studies. We are grateful for the invaluable assistance that made this publication possible. In particular, we wish to thank:

Dr S.T. Allman
Secretary, Advisory Committee on Medical Training, Directorate-General for Internal Market and Industrial Affairs, Brussels, Belgium

Dr N.-H. Areskog
Professor, Department of Clinical Physiology, Medical Faculty, University of Linköping, Sweden

Mr J.J. Artells
Director-General for Health Planning, Ministry of Health and Consumer Affairs, Madrid, Spain

Dr Margarita Baron Maldonado
Dean, Faculty of Medicine, University of Alcala de Henares, Madrid, Spain

Dr B. Coskun
Chief, Mental Health Department, General Directorate of Primary Health Care, Ministry of Health, Ankara, Turkey

Mr B. Eklundh

Head of Division, Secretariat for Coordination and International Relations, National Board of Health and Welfare, Stockholm, Sweden

Dr I. Forgacs

Professor and Director, Institute of Social Medicine, Postgraduate School of Medicine, Budapest, Hungary

Dr Maria Luisa Garcia Tunon

Continuing Education Section, General Directorate of Health Planning, Ministry of Health and Consumer Affairs, Madrid, Spain

Dr A. Goubarev

Scientist, Health Manpower Planning, World Health Organization, Geneva, Switzerland

Ms Rosemarie Gumpert

Institute for Health Care Education (Continuing and Further Education), Munich, Federal Republic of Germany

Dr P. Hamilton

Professor of Community Health and Chairman of the Division of Community Health, London School of Hygiene and Tropical Medicine, United Kingdom

Dr V.A. Haralambides

President, Centre for Continuing Medical Education, Athens, Greece

Mr J. Hultin

Division of Manpower and Educational Planning, National Board of Health and Welfare, Stockholm, Sweden

Dr M. Isokoski

Professor and Chairman, Advisory Board, Continuing Education Centre, University of Tampere, Finland

Dr J.-F. d'Ivernois

Professor and Director, Department of Pedagogy of Health Sciences, UFR de santé, médecine et biologie humaine, University Paris XIII, Bobigny, France

Dr Z. Jaksic

Professor, Andrija Stampar School of Public Health, Medical Faculty, University of Zagreb, Yugoslavia

Dr J.G. Jordanov

Vice-President, Medical Academy, Sofia, Bulgaria

Dr Hannah Kedar

Head, Psychological Assessment and Follow-up Centre of Medical Education, Hadassah Medical School, Hebrew University, Jerusalem, Israel

Dr M. Kjærgaard Hansen

Deputy Director-General, National Board of Health, Copenhagen, Denmark

Dr P. Klotz

Head, Medical Department, Hospices civils "Saint-Morand", Altkirch, France

Dr J.M. Martinez Carretero

Educational Unit, Institute of Health Studies, Barcelona, Spain

Dr A. Mejia

Director, Colombian Association of Faculties of Medicine, Bogotá, Colombia

Dr J.-P. Menu

Medical Officer, Human Resources Management, Development of Human Resources for Health, World Health Organization, Geneva, Switzerland

Dr I. Möller

Regional Officer for Oral Health, WHO Regional Office for Europe, Copenhagen, Denmark

Dr J.P. Neves Nunes dos Santos

Assistant Director, Instituto de Clinica Gera da Zona Sul, Ministry of Health, Lisbon, Portugal

Dr Maria Nolla

Institute of Health Studies, Barcelona, Spain

Dr A. Oriol-Bosch

Professor and Director, Institute of Health Studies, Barcelona, Spain

Dr B. Paccagnella

Professor and Director, Unit for Epidemiology and Community Medicine, Department of Paediatrics, University of Padua, Italy

Dr P. Saturno

Assistant Director-General for Health Planning and Promotion, Ministry of Health and Consumer Affairs, Madrid, Spain

Dr J.A. Schraag

Professor and Director, National Council for Continuing Medical Education, Soesterberg, Netherlands

Dr K. Spies

Professor and Rector, Academy of Postgraduate Medical Training, Berlin, German Democratic Republic

Mrs J. Spratley

Lecturer, Department of Community Health, London School of Hygiene and Tropical Medicine, United Kingdom

Ms Elisabeth Stussi

Regional Officer for Nursing, WHO Regional Office for Europe, Copenhagen, Denmark

Miss W.W. Thomson

Nursing Officer (Education), Scottish Home and Health Department, Edinburgh, United Kingdom

Dr F. Vartanian

Professor and Pro-Rector, Central Institute for Advanced Medical Studies (CIAMS), Moscow, USSR

Dr H. Vuori

Chief, Research Promotion and Development, WHO Regional Office for Europe, Copenhagen, Denmark

Dr A. Wojtczak

Professor and Head, Department of International Health, Medical Centre for Postgraduate Education, Warsaw, Poland

Foreword

Change is the heart of the health for all movement. One of the most radical changes is the move to primary health care, health promotion, prevention and rehabilitation, and away from curative care. To bring about this change, the education of health professionals must be re-oriented. But most of the health professionals who will be working in the year 2000 are studying now or have already completed their studies. Continuing education must therefore be the single most potent force for implementing the changes that are to bring about health for all by the year 2000.

For years, it seemed that the answer to countries' health problems was the training of more health professionals. Continuing education was seen simply as a way of maintaining and enhancing the skills of individual health professionals. When physicians began to have difficulty finding employment, it became clear that the problem of health personnel development was not supply but distribution. In fact, what the community required in terms of health services and what the academic world was able and willing to supply were two different things.

Considerable efforts have been made since the Alma-Ata Conference in 1978 to enhance the relevance of training programmes for all categories of health worker. This has not been easy, in large part because of the division between the health sector and the education sector. Training in universities and institutions has been particularly resistant to change. Some new medical schools are adopting community-oriented programmes in line with the primary health care approach. There is also an increasing trend towards postgraduate training in general practice and family medicine. It is clear, however, that educational programmes for physicians throughout the European Region are still heavily biased towards hospital-based specialties.

Changing curricula is a long and complex task, but it is of the utmost importance that health personnel are trained on the basis of the needs of the health system and of the community. The tide is definitely on the turn, however. In 1987, the rationale for reorienting the education of health personnel was formally established in a document presented to the WHO Regional Committee for Europe; and a resolution was passed requesting the Regional Director to identify the educational changes needed to support health for all.

Several associations in the field, such as the Association for Medical Education in Europe and the Association of Medical Deans in Europe, have declared their willingness to help implement this resolution. In fact, at the annual conference of these two associations in Dublin in 1987, held jointly with a meeting of the World Federation for Medical Education, the participants showed a very positive attitude towards the health for all policy, many of them committing themselves to take part in specific collaborative activities with the Regional Office. The following year in Lisbon, these three organizations held a ministerial consultation for medical education in Europe, in conjunction with the Ministers of Health and Education of Portugal and the Regional Office, co-sponsored by the United Nations Educational and Cultural Organization (Unesco) and with support from the Gulbenkian Foundation. At the end of the meeting, the national delegations present issued the Lisbon initiative stating their awareness of how much needs to be done to change medical education in Europe. With the support of these delegations, success must be possible.

In a similar vein, the Association of Schools of Public Health in the European Region set up a task force with the Regional Office in 1987 on the training of health professionals for health for all. This task force began preparing learning materials for public health personnel based specifically on the regional targets for health for all. The Association has continued to work in close collaboration with the Regional Office since then.

It was also in 1987 that the Regional Office carried out 10 case studies in several European countries, to investigate new approaches to the continuing education of health personnel and practices in that field. Ways and means were identified to develop systems and programmes of continuing education, that would take into account changing national needs and health for all policies, and lay emphasis on primary health care. These case studies and a further 19 country reports form an important part of this publication. They show that if continuing education is to be used as an instrument for change, the attitudes and *methods prevalent in the field today must be changed. With the growing commitment of our Member States to the goal of health for all through primary health care, and the committed involvement of the most influential nongovernmental organizations in the field of medical education, I am convinced that continuing education can be a force for change in the fight for health for all.*

J.E. Asvall
WHO Regional Director
for Europe

1

Introduction

The values of health care systems are being reappraised and challenged in most countries. The central issues are the relevance and utility of the health care provided compared with the resources invested in health. The situation in the European Region is characterized by two basic facts. First, despite the substantial financial resources devoted to health care during the past 40 years, resulting in new drugs and medical technology, the population is not as healthy as it could be. Second, massive inequalities in health persist despite the overall high level of development in the European Region and the advanced scientific, economic and educational level of most countries.

Health for all by the year 2000

World Health Assembly resolution WHA30.43 in May 1977 stated that:

> the main social target of governments and WHO in the coming decades should be the attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.

The European Region was thus faced with a very important challenge.

European Region of WHO

Within this framework, the WHO Regional Committee for Europe adopted a broad health policy for the whole European Region for the first time ever in 1980. This regional health for all strategy outlined four main areas: lifestyles and health; risk factors affecting health and the environment; reorientation of the health care system itself; and the political, managerial, technological, personnel, research and other support necessary to implement the desired change in the first three areas.[a] In 1984, the Regional Committee decided to strengthen this regional health policy by adopting 38 regional targets that clearly specified the goals the Region as a whole has to achieve by the year 2000 to solve the problems identified in the 1980 regional policy document.

Targets for health for all,[b] published in 1985 by the Regional Office, outlines four areas of improving health for European countries to focus on: reducing existing health inequity between countries and between groups within countries; adding life to years, by improving people's opportunities to develop and use their health potential; adding health to life, by increasing the number of years of life free from major disease and disability; and adding years to life, by reducing premature mortality from certain diseases and accidents. Targets were also set for factors influencing lifestyles and health, improving environmental health, improving the functioning of health services and strengthening the resources for health in national health policies, and in personnel development.

Health personnel development

As human resources are crucial in achieving health for all by the year 2000, governments have to take vigorous and carefully planned action to ensure that there will be sufficient and appropriate health personnel to implement their strategies without producing excess personnel. In this spirit, target 36 of the European strategy for health for all states:

> Before 1990, in all Member States, the planning, training and use of health personnel should be in accordance with health for all policies, with emphasis on the primary health care approach.[c]

Primary health care, supported by secondary and tertiary care, is emphasized in the strategy for health for all. It is not only the entry point of the health care system but also the key to achieving greater equity, preventing disease, promoting health and providing adequate treatment and rehabilitation services. The primary health care approach implies that:

- the focus of care should shift from curing illness to promoting positive health;

---

[a] **O'Neill, P.D.** *Health crisis 2000.* Copenhagen, WHO Regional Office for Europe, 1982.

[b] *Targets for health for all.* Copenhagen, WHO Regional Office for Europe, 1985 (European Health for All Series No. 1).

[c] *Ibid.*, p. 141.

— continuous and comprehensive care should replace episodic care;

— the health care system should be organized in well coordinated teams that include general practitioners and other personnel; and

— health should be promoted through promotion of intersectoral collaboration, community participation and personal responsibility.

This approach requires careful reorientation of the attitudes and skills of health personnel throughout the education and training continuum, including undergraduate or basic training, postgraduate or specialized training and continuing education.

Need for continuing education

The training of health personnel and its relevance to health needs is thus one of the most important activities of WHO.

As most of the health professionals who will be working in the year 2000 are now students or have already completed their studies, systems of continuing education should be developed that allow practising health professionals to improve their skills and to adjust their work according to the health needs of the population. Continuing education programmes should help health workers to adapt themselves to the changing patterns of health care and public health administration and thus better to serve the community. Continuing education needs to adapt to changing national health needs and policies for health for all and to emphasize primary health care. New methods, including self-directed learning methods, must thus be developed and individual members of health teams must be given the opportunity to learn how to solve problems common to all members of the team. Meeting the needs specified in the health for all targets requires adopting innovative experiences, using the expertise of teachers, managers and health administrators, and cooperating closely at various levels of the health care system with health personnel organizations and with the education sector to ensure coordinated training of health personnel.

New methods

Problems

The problems of health personnel development in support of health for all in the European Region were addressed at the thirty-seventh session of the Regional Committee in September 1987. It was stated that many countries lacked clear policies on the reorientation of the planning, training and use of health personnel in accordance with the health for all strategy. Three professions were identified as needing immediate attention: public health managers, doctors and nurses. Agreement was reached that a comprehensive document would be developed to synthesize the problems confronting the development of health personnel in the European Region, taking into consideration the requirements of policy implementation towards health for all in Member States. This document would then be used in a broad series of debates with health authorities and personnel, and especially with training institutions, to induce the changes in education required to achieve health for all.

Initiatives

In the mean time, the WHO Regional Office for Europe established a specific programme to investigate continuing education. The programme gathered information on how Member States organize continuing education. In addition, several case studies were commissioned to gather experiences on new approaches to continuing education.

In October 1984, a Consultation on Multiprofessional and Continuing Education was convened in Copenhagen. This Consultation recommended that "a study . . . be conducted on the current situation and trends in continuing education systems in selected European countries".

Action

The first eight country studies were reviewed at a meeting on the study on systems and organization of continuing education at country level, in Copenhagen in April 1986. This meeting recommended that additional country reports be solicited, particularly from the less developed countries. In addition, the meeting prepared a detailed protocol for the selection and reporting of specific case studies from several countries.

A total of 19 country reports and 10 case studies were available for analysis at the Workshop to Promote the Use of New Methods in Continuing Education, in Barcelona in December 1987. This meeting was convened as the final step towards the preparation of this publication.

2

Planning, implementing, evaluating and organizing continuing education for change

World Health Assembly resolution WHA27.31 regarded continuing education as an integral part of the total health and education system and underlined its importance to health authorities in achieving and maintaining high quality in health care. In 1977, the Regional Committee for Europe decided to make continuing education of health personnel and its evaluation the topic for its technical discussions in 1979. The concern of WHO and the Member States about the need for continuing education has grown since then.

The purpose of continuing education

A force for change

What are the goals of continuing education? *Continuing education of health personnel and its evaluation*[a] states, "The primary purpose of continuing education is to make health professionals more competent in their existing employment". In the present context, this definition is restrictive. The Workshop to Promote the Use of New Methods in Continuing Education concluded that it may be more positive to think of continuing education as a process designed to assist health professionals to adapt to and to take part in change. Health professionals are thus seen not as technicians employed to carry out specified tasks but as mature, well educated professionals who can be expected to contribute significantly both in their immediate day-to-day responsibilities and, more broadly, together with their team and beyond. The first definition assumed a relatively passive role for health professionals in making them more competent in their existing employment.

---

[a] *Continuing education of health personnel and its evaluation:* report on the technical discussions at the twenty-ninth session of the Regional Committee for Europe. Copenhagen, WHO Regional Office for Europe, 1980 (EURO Reports and Studies No. 33).

Assisting health professionals to adapt and to contribute to change assigns them an active role, in which they are expected to examine critically a proposed change for its relative merits and potential side effects, and to make reasoned decisions on how to adapt themselves appropriately. Similar intellectual thought processes, as well as creative decisions and actions, are promoted when health professionals are invited to take part in introducing and implementing change.

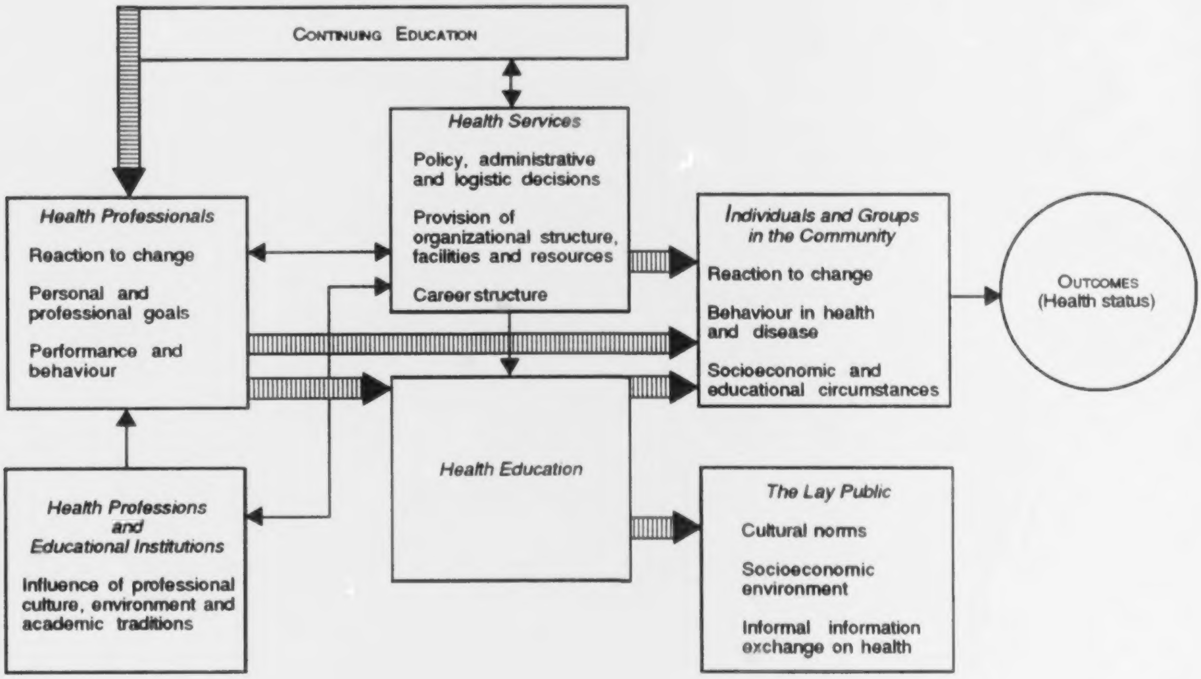
Primary health care

The present emphasis on primary health care is a typical example of the need to assist health personnel to adapt to and to participate in change. Members of primary health care teams, workers at secondary and tertiary care facilities and administrators need to be given opportunities to consider the implications of primary health care, including the effect on the daily practice and related skills of health professionals and how they can collaborate with others to further the aims of primary health care. Discussing these issues encourages health care workers to identify and acquire the necessary additional knowledge, understanding and skills — and, of equal importance, helps to create appropriate attitudes. Continuing education is thus not just the presentation of information for passive absorption by health professionals; they should achieve a true understanding of the desirability and nature of change and thus actively participate in implementing change.

An integral part of a strategy for change

Continuing education attempts to prepare health professionals for informed participation in change. While continuing education contributes to change, other factors are invariably involved that may have an equal and even greater effect on the outcome. Continuing education for change should not, therefore, be planned in isolation. It should be a deliberate, integral part of a systematic approach to change. Thus, for example, a strategy for change may also involve political, financial and administrative action. The logistics of adequate, appropriate and well timed supplies may be important. Involving the community in the impact of an impending change in health care may also be critical to a successful outcome. Fig. 1 illustrates the interdependent relationships that should

Fig. 1. A simplified illustration of the complex relationship between continuing education and the result of change in health care outcomes


CONTINUING EDUCATION
Health Services
Policy, administrative and logistic decisions
Provision of organizational structure, facilities and resources
Career structure
Health Professionals
Reaction to change
Personal and professional goals
Performance and behaviour
Individuals and Groups in the Community
Reaction to change
Behaviour in health and disease
Socioeconomic and educational circumstances
OUTCOMES (Health status)
Health Education
Health Professions and Educational Institutions
Influence of professional culture, environment and academic traditions
The Lay Public
Cultural norms
Socioeconomic environment
Informal information exchange on health

Note. The wide arrows indicate planned intervention.

be addressed when change in health care is planned and implemented. These complex relationships are also important in planning, implementing and evaluating continuing education programmes.

Planning a continuing education programme

An example

A brief example illustrates the need to plan continuing education as an integral part of an overall strategy for change. Many years ago, a campaign was mounted in a particular country to persuade mothers and their young daughters to purchase only carefully fitted shoes. An animated cartoon film with specially composed music was commissioned to convey, in the guise of an adventure story, the agony and the ecstasy of little toes in shoes that fit badly and well, respectively. A linen cloth was printed with happy scenes from the film, to be offered to schoolteachers who would use it as a visual focus while their classes discussed what they had seen in the film. The purpose, content and suggested use of the film were carefully explained in a leaflet for teachers. The box containing the film included copies of an inexpensive booklet for the girls to buy and take home. This contained another cartoon story for the girls, to reinforce the message, and a separate pictorial message for their mothers. Pharmacists were also encouraged to sell this booklet. The film was shown in numerous schools in all parts of the country, and many booklets were distributed. Nevertheless, all these measures had little effect. Shoe manufacturers and managers of shoe shops had not been approached. Shoes in different widths were not generally available, and very few shops were prepared to measure the feet of small customers. The nature of the change required had clearly not been analysed in sufficient detail. If the overall aim was to ensure that toes developed normally, persuading mothers and daughters to buy well fitting shoes could only be one aspect of the entire task. In any case, it might have been more cost-effective in the long run to concentrate on manufacturers and shoe shops rather than on mothers and daughters.

The nature of change and the factors involved

There are several questions that should be answered to define the precise nature of a desired change and the numerous factors involved in successfully introducing and implementing that change.

- What is the final goal of the change?
- How different are the new procedures or activities from the present ones?

- What are the (assumed or established) advantages and the (suspected or known) disadvantages or constraints of the change?
- What needs to be done to introduce and then to implement and maintain the change?
- Who will be involved in which activities, at what levels of the health care system, in what other sectors and in the community?
- What new responsibilities will people be expected to assume?
- What new skills will people need to acquire?
- What additional facilities, resources and incentives will be required?

Consultation and cooperation

The broader context

This list emphasizes that continuing education is only one of several processes involved in introducing and implementing change. Everyone who is to participate in change should therefore cooperate, to agree on the sequence of steps involved in the change, and on a timetable that indicates when continuing education activities for different personnel form part of the overall strategy for change. The planners of change need to consider the attitudes, aspirations, strengths and constraints of the people involved in change, as well as the physical facilities and resources needed to introduce and implement change. Continuing education programmes should be planned in this broader context.

What categories of health professional or administrator should participate in a particular continuing education programme? Should the programme benefit several professions or only one? What role should continuing education fulfil? Is the goal to introduce the aims and concepts of a particular change, and thus to prepare a group intellectually and possibly emotionally for change? Should continuing education involve professionals in deciding how to introduce and implement change in the community? Is the goal to assist professionals to acquire new skills considered to be necessary to implement change? In the past, information was presented and it was expected that this would be sufficient to ensure appropriate performance and behaviour from recipients. Experience has shown that this is seldom correct. Indeed, it is simplistic to postulate that the mere acquisition of new information enables health professionals to carry out a variety of new tasks. The technical discussions at the twenty-ninth session of the Regional Committee in 1979 emphasized: "There is a need to define the objectives of continuing education since, unless these are specified, the planning of

Need to specify objective

programmes and their evaluation becomes extremely difficult''.[a] The outcome of continuing education should be specified in terms of what the participants should be able to do that they could not do or could not do as well before the planned intervention. These objectives then help to plan the components of the programme and their sequence within the programme. So, for example, a particular objective may be so complex that it requires several different learning experiences to enable the participants to acquire the ability defined by that objective.

Process of a learning experience

Detailed analysis of the new skills that are required and how they are to be applied should start the planning of a programme of continuing education. It is then possible to plan the appropriate nature and sequence of learning experiences. Each learning experience consists of content (what is to be learned) and process (how learning is to be facilitated). Process is paramount in shaping the attitudes and subsequent behaviour of professionals. Effective learning depends on repetition and reinforcement and on repeated opportunities to practise new skills and to apply new skills in realistic situations.

Table 1 provides a general overview of types of learning tasks and appropriate learning experiences, indicating how different opportunities for learning can be planned in a logical sequence to support specific learning tasks.

Resources for learning

Once a timetable has been drafted of the sequence of learning opportunities, the resources required for each activity in the timetable can be determined. These include: the material used within each learning session, such as written texts for individual study or volunteers to act as patients for practice in a controlled environment; preparing or acquiring learning material and equipment, transport for practice in the field and accommodation for participants; budgeting; and, of course, recruiting and training experts to act as tutors and supervisors. Although the logistic requirements can only be specified towards the end of planning, they are essential to the successful implementation of a programme.

---

[a] *Continuing education of health personnel and its evaluation:* report on the technical discussions at the twenty-ninth session of the Regional Committee for Europe. Copenhagen, WHO Regional Office for Europe, 1980 (EURO Reports and Studies No. 33), p. 8.

Table 1. Some learning tasks and related learning experiences

Task	Experience				
	Lecture or or demonstration	Small group discussion	Self-directed environment	Practice in controlled environment	Normal working environment
Orient	x				
Acquire knowledge and understanding	x	x	x		
Consolidate knowledge and understanding		x	x		
Apply knowledge and understanding		x		x	x
Practise skills		x		x	x
Change attitudes		x		x	x

Implementing a continuing education programme

People who are responsible for implementing a programme of continuing education should be fully informed about the nature and purpose of the change to be adopted and the role of this programme in the strategy to achieve this change. They have to take overall responsibility for ensuring that the essential logistical support is available at the right time and place. Perhaps the most vital element is appropriately selecting and briefing the tutors, supervisors and discussion group leaders who are to help and assist in the process of learning. It is crucial that they be familiar with the aspects of change that affect how health professionals are to be encouraged to adapt to and to participate in change. This section therefore briefly discusses change and some aspects of adult learning.

Reaction to change

If the fundamental goal is to employ continuing education as a force for change, an educational programme should be based on how people and groups of people react to a proposed change and thus what is most likely to facilitate and support change. The health professions are naturally

Growing familiarity with change

conservative. People are unlikely to advocate change unless they are first persuaded that change is really needed. Thus, it is normal to stigmatize a proposed new idea, plan or activity as unnecessary, unreasonable, impracticable, downright dangerous and even ridiculous. People can then reassure themselves that a ridiculous notion is clearly not worthy of further thought, much less action. If people are nevertheless persuaded further to consider proposed change, they pass through several emotional stages similar to those experienced in bereavement. After all, adopting something new and strange involves giving up something old and comfortable. As people become more familiar with the change and what it involves, resistance tends to decline. Specifically, if a group of colleagues is involved in the change and if the proposal is discussed over a period of time in a non-threatening atmosphere, a favourable consensus is more likely to emerge. Acceptance depends on growing familiarity with new conditions, an essential ingredient of any major change. Unless a positive climate of opinion is established, change may never be implemented or is very likely to be abandoned or neutralized before long.

Reassurance and incentives

Reassurance and incentives are also essential ingredients in change. People need to be reassured that the power they hold will not be diminished; that increased effort and demand on their time will not be unreasonable; that new techniques or methods can be mastered successfully; and, indeed, that the change itself will succeed. Incentives are especially important whenever people are asked to adopt activities that are not entirely within their existing range of expertise and interest. For most health professionals, this applies very well to any change that requires additional involvement in education or management.

Leadership

People react differently to change. Some may resist stubbornly; others are preoccupied with different problems or concerns and may be content to follow a lead. Still others wish to foster and facilitate change, though not uncritically. Indeed, people who are prepared to counsel against ill-considered excesses and potentially adverse side effects of a proposed change are valuable. It is essential that the process of change be guided not only to promote and maintain support for the change but also to guard against harm caused by extreme enthusiasm or criticism. Leaders must be sensitive to the stresses and tensions that are likely to arise. They must also convey a feeling of trust in delegating to others and thus give as many of their colleagues as possible a sense that they control the initiation and implementation of the change. Everyone involved in change needs to feel fully informed and to be able to contribute.

Implications for continuing education

Opportunities for active learning

The actions and reactions of people facing change have clear implications for conducting a continuing education programme intended to assist in introducing and implementing change. The people for whom the programme is intended may need repeated opportunities, in a non-threatening environment, to discuss and examine the nature and implications of the change and how they can contribute to it. People only identify what they need to learn to participate fully in the proposed change when they become familiar with and thus accept the change. Thus, to adapt to a change, health professionals need to be assisted in critically evaluating its merits, constraints and potential side effects, and in identifying and managing their own learning. A continuing education programme for change does not merely transfer new information but is instead a network of sophisticated processes. Tutors or facilitators of continuing education thus need to become familiar with these processes and their educational consequences.

Small group, problem-based learning

Adults learn best when study is perceived as relevant to their personal interests, when they are active in formulating and following up their questions, when they have an early opportunity to check how well they have learned, and when they can practise applying what they have learned. Learning that takes place in the context in which it is applied is remembered longer and is applied more effectively than conventional learning, which is frequently quite unrelated to the real world. These insights into adult learning have led to the development of small group learning through discussion, based on the presentation of problems from real life. Such problem-centred learning facilitates the interchange and mutual testing of ideas that is essential in changing attitudes. Problem-based learning also encourages the rational exploration of a problem and related factors, the sharing of existing knowledge and experience of attempts to solve the problem, and the identification of what needs to be learned to resolve the problem. Once individual people have completed their learning tasks, the group can be reconvened. During this follow-up session, people can share what they have learned and thus determine how effective their learning has been. As the shared information is used to deal with the problem in greater depth, this is also an opportunity to practise applying new knowledge and insights. Nevertheless, facilitating problem-based and small group learning is not easy. Tutors of small groups should seek guidance in how to recognize and to use group dynamics and how to facilitate truly effective problem-based learning.

Participation in change

A continuing education programme for change should also provide guidance and practice in how to participate in introducing change. Health professionals involved in change inevitably encounter administrators, other professionals, people in other sectors and members of the public who are not yet familiar with or in agreement with the change. These health professionals should be helped to see the change and its implications from the viewpoint of other people who are not yet familiar with or in agreement with the change. Health professionals should be encouraged to think of ways to explain (not just inform) and to reassure that can be understood and appreciated by other people. Health professionals should be given opportunities to practise such empathic activities in a controlled, non-threatening environment, before they apply the newly acquired skills in actual problem situations.

Evaluating a continuing education programme

Aims and objectives

Continuing education should be evaluated in the context of its role within the overall strategy for change. The aims of a programme indicate what that programme intends to contribute in terms of health outcomes, such as reducing morbidity and mortality caused by alcoholism. The objectives of the programme, however, should be confined to specifying what health professionals should be able to do and how they should do it, as a result of participating: for example, identify early signs of alcoholism and apply preventive intervention. The eventual outcome of health care is affected not only by the impact of a continuing education programme but also by other factors in health care outlined earlier in this chapter. Thus, although continuing education should assume a defined and major role in any strategy for change, it should not be held solely responsible for the outcome of that plan. It is thus inappropriate and unrealistic to expect that the success of a continuing education programme should be evaluated based on evidence of change in the health of the population. The outcome of a continuing education programme can only be evaluated in terms of the objectives of the programme.

Evaluation of the outcome of continuing education is therefore restricted to answering these questions:

- Are professionals able to do what the objectives specified they should be able to do as a result of participating?
- Do the professionals actually perform and behave in their day-to-day practice as the objectives specified they should?
- How acceptable is this day-to-day practice to the professionals and to their colleagues and patients?

- How much extra time, effort and resources are used in day-to-day practice as a result of the continuing education programme?

Evaluation of outcome thus uses acceptability, effectiveness and efficiency as its criteria of success, in relation to the objectives of the programme. These results can then be used to assess what the programme contributed to the strategy for change.

Monitoring

Just as outcome can be evaluated, evaluation can and should be monitored. The criteria used to evaluate outcome can be used to monitor the process and progress of a continuing education programme. How acceptable is the programme to its participants and its tutors? Do the participants progress towards achieving the objectives as the planners anticipated? Does the use of time, effort and resources exceed that predicted by the planners? Careful documentation of intentions and actual events can answer such questions and helps to improve the programme and its implementation.

Evaluating outcome

How can outcome be evaluated? Past evaluation of programmes tended to emphasize testing for recall of knowledge. Evaluation is frequently restricted to administering questionnaires that elicit how well programme participants accepted a programme. Although questionnaires do address an aspect of acceptability, recall of knowledge only partly measures effectiveness. Knowledge is necessary to inform decision-making in clinical practice, in promoting and maintaining health and in preventing ill health. Nevertheless, a professional may possess skills or knowledge, but this does not guarantee the ability or willingness to apply such skills or knowledge, which is one of the objectives of a continuing education programme. Tests that assess the ability to apply skills can be validated by giving professionals a genuine opportunity to demonstrate their ability to apply the specified skills. For example, an essay question asking for a verbal description of a manipulative procedure is not valid, as it does not allow professionals to demonstrate their ability to carry out this procedure. Thus, observation of actual, practical performance is invariably preferable to tests that use paper and pencil in assessing ability acquired from participating in a continuing education programme.

Validity of tests for competence

Selection of appropriate tests

A WHO publication (*Assessing health workers' performance: a manual for training and supervision*)[a] and a WHO document (*Catalogue of*

---

[a] **Katz, F.M. & Snow, R.** *Assessing health workers' performance: a manual for training and supervision*. Geneva, World Health Organization, 1980 (Public Health Papers No. 72).

instruments for the performance assessment of health workers)[a] are particularly helpful. They explain the theory and provide examples of selecting tests best suited to assessing particular abilities. These and other publications (listed in Annex 2) also assist in selecting appropriate tests to assess the willingness of professionals to perform and behave in specific ways, not only under examination conditions but also in daily practice over an extended period of time. These publications also offer guidance on reliability — whether the same professional performs nearly identically on different occasions and whether assessors make identical or similar judgements of performance on a test.

Reliability of tests

Summary

It is worth emphasizing once more that a continuing education programme, especially in the context of primary health care, is only part of a broader strategy for change and that such a programme should be designed specifically to contribute towards the success of the strategy. The success of a programme can therefore be evaluated only in relation to its own objectives: the new or enhanced skills to be applied by the professionals who participated in the programme. The success of the entire strategy for change should therefore be evaluated in relation to its objectives. It will then be possible to evaluate the specific contribution of a continuing education programme towards implementing the strategy for change.

Organizing continuing education for change

Earlier sections of this chapter have emphasized that continuing education should be an integral part of a coherent strategy for initiating and implementing change. It is therefore reasonable to postulate that the organization responsible for continuing education should not be entirely separate from that responsible for administering health care, whether at district, regional or national level. More positively stated, the organization responsible for continuing education should be represented on a consultative or coordinating body responsible for planning and implementing strategies for change in health care. Its members should include health authorities and professions, educational institutions, and also other sectors that directly or indirectly influence health. Only in this

Representation

---

[a] *Catalogue of instruments for the performance assessment of health workers.* Geneva, World Health Organization, 1981 (unpublished document HMD/81.6).

way can continuing education be an integral part of an overall strategy for change and be assured of the political will and resources necessary for its tasks in this strategy.

Role of the professions

The professions should play a predominant role in organizing continuing education because their members need to be closely involved in determining the content and process of their further education. The professions need substantial autonomy in determining how the continuing education of their members is to contribute to a strategy for change.

The tasks of an organization responsible for planning, implementing and evaluating continuing education are twofold. The first is to liaise with other authorities, organizations, institutions and professional associations:

- to determine which changes require continuing education;
- to identify the role and timing of continuing education in the strategy for change;
- to identify other reasons for continuing education, such as professional development;
- to plan appropriate programmes of continuing education;
- to organize the recruitment, training and maintenance of tutors and other staff;
- to organize the purchase and distribution of required equipment and materials;
- to organize the availability of appropriate meeting sites and other facilities;
- to arrange for appropriate incentives for participants;
- to arrange for health personnel to be available for continuing education activities (time off from work, transport and other logistic tasks);
- to monitor ongoing programmes;
- to arrange evaluation of the outcome of programmes; and
- to participate in evaluating strategies for change.

The second task is to negotiate with other authorities, organizations and institutions the budget and finances for administering the organization, and the budgets and finances for specific continuing education programmes.

Conclusion

This chapter outlines key principles that should be addressed by people involved in the numerous changes intended to improve the health of a population. Continuing education is justified first and foremost as a means for implementing change. If it is to be a successful force for change, several conditions must be met. The planning and timing of continuing education activities must be an integral part of a broader, and frequently intersectoral, strategy for change. In return, continuing education expects to receive political and administrative recognition and logistic support. If health professionals are to benefit from participating, to adapt themselves to change and to participate in change, they need to be consulted in planning and implementing this further education. This presupposes that continuing education is administered by the professions and their educational institutions.

Everyone involved in a strategy for change should become familiar with the nature of change and how change can be supported and maintained. In addition, professionals responsible for helping their colleagues to adapt to and to participate in change should examine the ways and means most likely to lead to acceptable, effective and efficient learning. They need to accept that it is no longer realistic to equate continuing education with the mere presentation of factual information, in the mistaken anticipation that such knowledge will be received, remembered and acted on by participants.

Continuing education as an force for change deserves to be taken seriously by policy-makers, by health administrators, by the health professions and by their educational institutions. It deserves to be appropriately funded, professionally organized and expertly implemented.

3

The present state of continuing education in Europe, with emphasis on primary health care

This chapter summarizes the insights and observations derived from the 19 country reports and the 10 case studies.

Country reports: insights and observations

Chapter 5 explains in detail how and why it was decided that detailed reports on the organization and conduct of continuing education in 19 countries in the European Region would be solicited.

Commissioning the country reports

The broad aims of the country reports were:

- to determine the feasibility of continuing education and its cost;
- to identify good practices, particularly in interprofessional continuing education;
- to identify research areas, including the need for evaluation; and
- to form the basis for future collaboration between countries and with WHO.

Factors to be considered

These aims implied that several factors would have to be considered and reported on, such as:

- the purpose and aims of continuing education in a country;
- the parties involved (participants, providers or teachers) and their motivation;

- the organization and administration of continuing education in the context of the continuum of education and the country's health care system;
- the strategies, tactics and methods of continuing education and how acceptable, effective and efficient they were judged to be.

This chapter will therefore address six questions.

1. What were the major aims of continuing education in different countries, and were specific objectives identified in terms of needs and related skills?

2. What strategies, tactics and methods were reported that were: practicable and acceptable to participants in and providers of continuing education; effective in modifying performance and behaviour in the provision of health care; and efficient in terms of the time, effort, resources and finances used by administrators, providers and participants?

3. What was done to ensure that everyone involved in continuing education was suitably prepared and motivated?

4. How and to what extent was continuing education integrated into the continuum of professional education?

5. How and to what extent was continuing education practised as part of developing health personnel within the country's health care system?

6. How and to what extent was continuing education evaluated?

Suggestions for the future, including the need for research, are discussed in Chapter 4.

Question 1

What were the major aims of continuing education in different countries, and were specific objectives identified in terms of needs and related skills?

The traditional view of continuing education is that it should be used to increase the effectiveness and efficiency of health professionals. In countries where priority health needs had been identified, such as the care of elderly people, continuing education focused specifically on enabling teams of health professionals to provide more effective care.

Change

The acceleration of change in recent years, not only in the methods but also in the organization of health care, had led to a quite new purpose for continuing education. It was more frequently used as a force for change, to help health professionals to adapt themselves to new tasks, frequently in new settings, such as collaboration in primary health care teams, adjustment from urban to rural practice conditions or adjustment to a newly introduced national health service system. In a few instances, continuing education that was intended to help in adapting to change had been taken a step further, as it assisted professionals in actively introducing change. Movement towards a more positive approach to continuing education, in which participants become active partners in defining their needs in further learning, seemed to be tentative but growing.

Competence in management

Continuing education designed to change attitudes and skills was being extended to other generally applicable skills, such as management. Although further education for managers and doctors in primary health care was gaining increasing recognition, not all countries of the European Region had realized how important capable management is to ensure the effective and efficient deployment of finite resources. People responsible for administering continuing education should also have access to management skills.

Primary health care

Several of the country reports referred specifically to national documents that identified primary health care as a major means for achieving health for all. Continuing education was seen as an important method to attain specific targets within the strategy for health for all. There were also efforts to use continuing education meaningfully and functionally to integrate primary health care with other levels of the health service structure.

Room for improvement

Improvement appears to be necessary in defining the aims of continuing education and specifying the skills required to meet specific health care needs. The personal needs of health professionals had not yet been addressed. From their viewpoint, improving personal capability is only one reason to participate in continuing education. Professionals also seek intellectual stimulation, which is not necessarily linked with the pragmatic demands of professional responsibilities. The link between intellectual stimulation and motivation is discussed again later under question 3.

The specification of overt objectives, or what professionals should be able to do better than they could prior to continuing education, is a demanding task in planning continuing education. This appeared to be accepted in principle but was not necessarily carried out in day-to-day practice. Far too frequently, objectives were stated in such general terms that they might have little value in practice. Indeed, where objectives were specified, they usually concentrated on the ability to remember facts rather than on the ability to apply knowledge to actual problems.

Question 2

What strategies, tactics and methods were reported that were: practicable and acceptable to participants in and providers of continuing education; effective in modifying performance and behaviour in the provision of health care; and efficient in terms of the time, effort, resources and finances used by administrators, providers and participants?

Political will

The countries studied appeared universally to accept the need closely to integrate continuing education with the operational needs of the health care system in response to the needs of the population (see question 5). The important role of political will is also generally recognized; without official recognition, adequate financial support and appropriate resources, continuing education can achieve relatively little. The appropriate recognition of continuing education as legitimate and essential must, however, be more than acceptance by governments. All personnel in the health services and in educational institutions, and members of the community need to acknowledge the tasks and needs of organizers and providers of and participants in continuing education.

Active involvement

Centralization and decentralization

In most countries of the European Region, awareness seemed to be growing that individual health professionals need to be involved in identifying the needs for continuing education and in planning, conducting and evaluating programmes. This, in turn, emphasized the organizational virtue of centrally coordinating overall policy and resource procurement but decentralizing detailed programme planning and implementation to address local conditions.

In-service continuing education

The constraints of staffing and other logistic considerations seemed to indicate that most continuing education should be conducted as an in-service activity, so that absence from work and the need for transport and subsistence allowances can be minimized. Local staff thus need to be fully used as teachers or facilitators and distance-learning methods are needed, especially when participants do not work at the same place. People planning continuing education programmes should consider not only health care needs and related skills but also how best to encourage people to learn, to acquire specific skills and to modify their attitudes. As learning depends on cumulative, reinforcing experiences, a programme should comprise a sequence of learning opportunities.

Self-directed learning

Self-directed learning, particularly through problem-based learning, had acquired increasing recognition and acceptance in principle. Nevertheless, not all teachers in the health professions precisely understood the practical and related benefits of these approaches to learning. A concerted effort is required in appropriately training teachers to free adult learning from the constraints of passive learning. Only too frequently, novel educational methods are adopted uncritically, without a full understanding of their strengths and weaknesses and how these can be optimized and minimized, respectively. When a method is adopted casually, as a fad, it is likely to be dropped equally casually because its misuse has led to disappointing results.

Multiprofessional education

Problem-based learning

Multiprofessional education was advocated repeatedly, particularly to improve the functioning of primary health care teams. The reasons for this joint education were readily accepted, but putting this into practice was not easy anywhere. Problem-based learning may offer the most promising prospect of success. In this approach, different health professionals meet as a group to consider a real patient or community problem. They contribute towards resolving the problem, using their different professional experiences. In the process, each professional identifies what he or she did not know and could not understand or what he or she could not do, such as explain something convincingly to a colleague. This leads to specific individual learning. When the group comes together again, its members share what they have learned and apply these new insights to the original problem. These sessions heighten each person's appreciation of the contributions of others to the tasks of the team.

Need for resources

Inevitably, the country reports emphasized the need for adequate resources: resources to operate a continuing education system, to implement individual programmes, and to allow individual health professionals to participate. Experience had shown that close collaboration between the authorities responsible for policy and resources, professional associations, educational institutions and, where appropriate, private foundations and firms could yield very satisfactory results without compromising their sometimes diverging interests.

Needs of participants

The needs of individual participants in continuing education should not be overlooked. They are frequently blamed quite unfairly for not participating, as they might need time away from their duties, other health workers to replace them for a prolonged period and support for travel and living expenses.

Need for systems

Many country reports recognized that isolated continuing education activities are of relatively little value. Adequate planning, implementation and evaluation can only be carried out by an appropriate organization with realistic resources, trained staff and integrated activities, and the entire programme must be closely related to the specific needs of the health care system and of the personnel for whom the education is intended. Thus, continuing education should be viewed as a coherent system.

Question 3

What was done to ensure that everyone involved in continuing education was suitably prepared and motivated?

The majority of studies reported that the state provided most continuing education. In a smaller group of countries, local government, independent health organizations, professional associations and private firms provided continuing education. In most countries the main providers cooperated with other partners, especially with universities, medical schools, schools of public health, regional and teaching hospitals and professional organizations.

Physicians were the main participants in continuing education, but in several countries nurses and other health professionals increasingly participated. Programmes tended increasingly to target several professions. Participation in programmes was entirely voluntary in one third of the countries.

The relationship of teachers or instructors to the providers of continuing education varied according to the type of provider. When continuing education programmes were implemented at central, regional or county level, teachers usually came from medical schools, institutions for postgraduate education or teaching or regional hospitals. Locally or community-based continuing education programmes were usually increasingly staffed by general practitioners and other primary health care professionals.

Motivation

Most country reports repeatedly mentioned motivation as a major issue. When there was a clearly enunciated political will, backed up by practical

Active participation and open communication

support, providers, teachers and participants were usually highly motivated. Nevertheless, political will and practical support alone did not maintain motivation for long. Active participation in decision-making and implementation seem to be important in determining motivation. Thus, an open network of communication between policy-makers, employers, the professions, and educational institutions is highly desirable. Similarly, active communication between providers, teachers and participants tended to support and maintain motivation.

Other factors essential in creating and sustaining motivation were educational methods that encourage active learning, such as problem-based learning and peer review, and learning that is perceived as contributing to career development.

Mandatory versus voluntary

Attendance at continuing education sessions was mandatory in some instances, and cogent arguments have been advanced to support such decisions. Elsewhere, it had been postulated that mere attendance did not necessarily change performance or behaviour, and that voluntary participation would be preferable and more consonant with the commitment to life-long learning that should characterize health professionals. This important issue merits further investigation and debate.

Managing health personnel involves responsibility for employing, deploying, retaining, supporting and developing health professionals. It has thus been argued that relevant and interesting continuing education attracts participants and ensures continuing participation. In this context, several country reports stated that solo practitioners, many in primary health care, found it difficult to leave their practices to attend meetings. The reports did not, however, provide information on informal continuing education, such as using distance-learning programmes and personal computer programs and reading journals.

Training for teachers and managers

Adequately preparing teachers in continuing education is critical in changing the education and training of health workers. Teachers need to be trained so that they understand their role. They should be able to promote the process of learning by guiding and assisting participants in continuing education in achieving specific learning objectives. Teachers should also be able to understand the working conditions and social atmosphere within primary health care teams. Such teachers are better prepared for programmes with a multidisciplinary orientation.

The need to train managers of continuing education was also stressed. Managing health personnel as a whole and managing continuing education programmes are very closely related, the latter being indispensable to the former. Systematically managing continuing education means much more than simply arranging courses or workshops; all aspects of managing health personnel are involved.

Training in educational methods was organized in some of the countries of the European Region, and in a few countries such training was one of the conditions of the teachers' employment contract. There were other countries, however, in which training in education was the exception rather than the rule. It would be of considerable interest to explore in detail the reasons why such training appeared to be relatively undervalued in some countries and the nature of training in the countries where it was taken seriously. The fundamental differences may be whether teaching was recognized and rewarded as a prestigious activity; whether it determined, at least in part, whether people were promoted in their academic or clinical career; and whether teacher training encouraged and supported self-directed learning through, for example, problem-based learning.

Question 4

How and to what extent was continuing education integrated into the continuum of professional education?

Single educational institution

There were four quite distinct organizational structures within the European Region. In one country, a single educational institution was responsible for organizing undergraduate, postgraduate and continuing education, as well as medical science research. Such a unified, central system appears to promote close coordination of the various phases of medical education, and it would be valuable to explore the potential and real advantages of this system as well as the constraints.

Separate undergraduate, postgraduate and continuing education

In other countries, the institutions for undergraduate or basic professional education had no direct responsibility for continuing education, but provided expertise through their academic staff, and facilities such as lecture theatres, for the delivery of continuing education. In this approach, the link between continuing education and undergraduate and postgraduate education was much looser, and the academic staff may have had less influence on the sequence, continuity and coherence of individual segments within a programme of continuing education. There may also have been some doubt as to the source and allocation of finances.

A single authority

The third arrangement placed undergraduate, postgraduate and continuing education under a single authority, such as a ministry of health. If this authority takes a close interest in the philosophy, aims and goals of the continuum of professional education, the transition of students from one stage to another can be ideal, and it ensures a coherent approach that can continue to respond to major changes in the structure of the health care system and in health care needs. If this authority only administers health care policy and the supply of personnel and other resources, the quality and direction of professional education may be adversely affected.

Combined postgraduate and continuing education

In several countries, institutes of advanced education for the health professions were responsible, under a ministry of health, for postgraduate or postbasic education and for separate continuing education for doctors, pharmacists and nurses. Such central institutes also guided similar, smaller training centres in other parts of the country.

Coordination of organizations

The fourth arrangement was perhaps the loosest of all. Undergraduate institutions were controlled by their parent universities, professional organizations assumed responsibility for setting standards, and the employing authority provided financial support for postgraduate training. Another combination of authorities and organizations assumes responsibility for continuing education. Such an arrangement tends to require subordinate coordinating organizations. Although this system, usually the result of growth over a long period of time, may be excessively complex, it tends to offer flexibility for experimentation and can adapt to changing needs and circumstances.

Question 5

How and to what extent was continuing education practised as part of developing health personnel within the country's health care system?

Development of health personnel

The policies and process of developing health personnel — planning, production and management — were closely related to the different systems of health care. In countries that had pronounced state responsibility for health care policy and process, the two were usually coordinated. This coordination included all phases of education: basic or undergraduate, postbasic or postgraduate, and continuing education. It covered most categories of health worker and members of primary health care teams. In other countries, policy and process were less comprehensive and less coordinated. Countries in which primary health care was being reformed maintained a close relationship between the reforms and the development of health personnel. In a minority of countries, the ministry of health was responsible for health care and health personnel development; more frequently another ministry, such as the ministry of education or culture, was responsible for university education.

Integration

Most countries integrated health services planning and health personnel development to some extent. Mechanisms to develop health service personnel usually concentrated on quantitative needs, such as producing a certain number of physicians, nurses or other health workers, in accordance with estimated needs expressed by the health service system. In most countries, continuing education did not focus on the integrated planning represented by the mechanism to develop health personnel. It was very promising that initiatives were being taken to develop methods to facilitate the integration of continuing education in developing health personnel. Nevertheless, there was room for further development.

Funding

Almost all the reports stated that the national health service system provided most of the funding. Financial aspects of continuing education had two dimensions: the direct costs of providing continuing education and the indirect costs of participating in continuing education. Direct costs are easy to estimate and measure, but indirect costs are more important and can amount to about 75% of the total cost. These costs were thus negotiated between providers and participants. Problems related to indirect costs were particularly sensitive and could hinder participation. Various aspects needed to be investigated.

- Could a health centre be closed at the time the team was participating in continuing education?
- Who would take over their activities and responsibilities?
- Would the employing authority be willing to replace the team with other health workers?
- Would this replacement influence the quality and continuity of care?
- How could the mechanism for developing health personnel and, in particular, health personnel planning avoid problems connected with absence from work because of participation in continuing education?

Career development

Most reports suggested that neither financial nor career incentives were provided to promote participation in continuing education. In countries where legislation made attendance mandatory, continuing education and career development were linked. Motivation is so central that further study of it should be made a priority.

Central coordination

Countries that had one organization that directed health services and health personnel development considered this arrangement optimal, particularly when executive responsibility was decentralized and delegated to the regions of the country. This organizational structure facilitated the use of long-, medium- and short-term plans, in which yearly plans could specify how human resources were to be deployed. In some of these countries, special postgraduate institutes acted as a functional link between health service requirements, health personnel development at undergraduate and postgraduate levels, and the need for continuing education.

Parallel systems

Countries in which the administration of health services and the education of health professionals were quite separate and in which professional associations or trade unions also played a role in continuing education had problems with communication and collaboration in planning and implementing continuing education programmes. The planning of continuing education programmes heavily depended on reliable information and on intrasectoral and intersectoral consultation and negotiation. The country reports considered this essential to a critical appraisal of the needs and priorities in continuing education. Close cooperation was especially necessary in developing continuing education for primary health care teams. The transfer of resources to continuing education for primary health care was possible only if communication and collaboration between policy-makers and providers of continuing education were securely established. The planning of continuing education programmes was not always based on priority targets in developing health services. In general, competence was not assessed and the quality of health care was not evaluated prior to programming continuing education.

Primary health care

Nearly all the country surveys reported enhanced efforts in adapting continuing education programmes to the needs of primary health care teams. Vertical and horizontal collaboration occurred. Continuing education for members of primary health care teams should help to strengthen professional links with higher levels of the health care system. This function was also essential to make intersectoral links with other providers of care; for example, social welfare services, who care for elderly and handicapped people. The horizontal dimension was even more important. The team approach between members of different health professions and other care-giving professions would be fundamental to effective community-oriented care. Thus, the planning of continuing education for primary health care teams would require close collaboration between people involved in organizing primary health and community care.

Question 6

How and to what extent was continuing education evaluated?

Current methods

Almost every country report said that evaluation of continuing education was a problem that had not yet been resolved. This did not imply that evaluation had been totally ignored. The usual method of evaluation included assessment of gain, mostly in memorized knowledge and sometimes also in skills, as assessed immediately after an educational activity. In some instances, essays on selected subjects had to be submitted at the end of a formal course. The most common topic for evaluation, the acceptability of continuing education programmes, was discussed by questionnaire or by verbal expression of personal opinion on the quality, usefulness and adequacy of a continuing education activity.

Several reports underlined the need to evaluate the long-term impact in terms of improved ability.

Outcome evaluation

One report argued that evaluating the impact of continuing education programmes on the quality of health care involved so many variables, including the organization of work, the motivation and personal situation of health workers, the dynamics and morale of a team, professional satisfaction and the level of relevant feedback, that it would be very difficult to obtain a meaningful result. Several reports simply stated that, owing to recent organizational and structural changes within the practice of primary health care and consequent changes in continuing education programmes, it was too early to undertake any evaluation.

Initiatives

Some reports mentioned interesting evaluation initiatives. Specialized bodies had been established to address the quality of health care, such as a national committee to evaluate the quality of health care and a foundation to evaluate medical practices and techniques by applying criteria established by consensus. These developments may lead to more specific definitions of the quality of care and hence to continuing education through peer review.

Monitoring

Monitoring of continuing education activities was seen as a decision-oriented process further to improve programme content and process. Conclusions from monitoring could provide information not only to improve but also to develop new programmes, policies and strategies. Monitoring of continuing education could also establish the frequency of activities, number of participants and cost.

Conclusion

There appeared to be an urgent need to specify the precise purposes of continuing education and its roles within a specific context. Only then would it be possible to identify what should be evaluated and thus how evaluation should be carried out. Unless the purpose, context and goals of a programme were stated in specific, unambiguous terms, evaluation remained a tantalizing problem that was impossible to resolve.

Case study reports: some observations and conclusions

Chapter 6 explains how and why the 10 case studies were commissioned. It was anticipated that these studies might stimulate and guide further developments in continuing education, particularly in primary health care. A case study is a detailed account of a single, well defined event. The present case studies describe events either in a particular geographical area or in a particular health care setting. Each has a specific target group and a particular approach to continuing education.

The studies

These case studies represented a fertile source of creative approaches to the challenges of continuing education. They ranged from collaboration between general practitioners and hospital staff to improve patient care, to collaboration between institutes and national officials in creating continuing education systems and in implementing continuing education programmes. Some studies reported methods in continuing education for change in, for example, caring for elderly people or preventing noncommunicable diseases. Others aimed at improving primary health care through enhanced teamwork and communication skills. A network of centres experimented with audiotape, videotape, compact discs and computers for gathering and disseminating new information; another study reported a carefully planned and implemented long-term programme that spanned 24 years. The importance of the new role of continuing education as a major force for change was repeatedly illustrated.

Continuing education for management

In another study, the need to promote leadership to implement a national health for all policy led to a programme designed to help personnel in health administration to implement the national health for all policy and primary health care at local level. A three-week course was devised as part of a three-year specialty training programme in public health management and social medicine for chief medical officers, directors of hospitals and their deputies, managers in health administration and education, and junior staff from departments of social medicine.

Distance learning

One programme was intended to encourage and improve teamwork and understanding of professional roles, communication between professionals and between professionals and clients or patients, communication with the community, and participation by members of the community in planning their own health care. The distance-learning materials were designed by a team including general practitioners, nurses, educational experts, consultants in specific subjects and other primary health care professionals. The educational activities consisted of self-learning with prepared distance-learning materials and two-day residential workshops.

Obstacles

Changes in health care policy, organization and methods required that continuing education assist health professionals, people responsible for policy-making and implementation and people who organized continuing education, in developing the attitudes and skills needed to adapt to and to participate in change. Achieving this task seemed largely to depend on moving the health care system to recognize the importance and integral role of continuing education, so that its activities could be appropriately planned, securely funded and realistically evaluated. The case studies and the country reports identified numerous obstacles to change. Many of these obstacles could be overcome by ensuring the active participation of everyone involved in continuing education, especially learners.

Participants

Although the case studies illustrated increasing participation by a broad range of professionals, the country reports indicated that doctors continued to be the largest single group of participants. Primary health care and team training were increasingly emphasized. Although several case studies provided imaginative examples of sensitive interprofessional continuing education, this task required further experimentation and development.

Sources of information

This chapter has drawn on the vast amount of information made available through the 19 country reports and the 10 case studies, and through the critical and creative discussions at the consultations and workshop that guided this project. Several aspects that need to be investigated and developed further, if continuing education for change is to flourish and live up to its promise, are discussed in Chapter 4.

4

Towards the future

Chapter 3 identifies several trends that are strengthening continuing education throughout the European Region, particularly emphasizing achieving health for all through primary health care.

Identified trends and concerns

This general movement appears to recognize that continuing education can be a powerful force for change. Continuing education should therefore progress from episodic activities for idiosyncratic purposes towards overtly planned programmes. These programmes should be based on specific health care needs and aimed at improving the care offered by individual practitioners and teams. The country surveys repeatedly emphasized that continuing education can promote collaboration in primary health care teams, improve management of resources (including staff) and effectively contain costs. These trends are based on a movement towards more centrally administered and organized continuing education, including increased involvement of governments through enacting legislation, establishing centres or institutes for continuing education, and training teachers. Reaccreditation and mandatory continuing education were also considered. Greater insight into the complexities of human behaviour in terms of learning and change was also being achieved. This has increased the demand for more sophisticated educational approaches, such as problem-based learning.

Progress towards better continuing education

What, then, would constitute further progress towards more acceptable, effective and efficient continuing education? This question could be approached from the different viewpoints of the health authorities and the need for health care, and the health professions, their members and their educational institutions. The health authorities may wish more actively to consult the professions and their educational institutions. The task is to explore organizationally and administratively how best to ensure an ongoing, viable system of continuing education that can respond to many different needs in the community, in the health care system and in the care-giving professions. Such consultations would develop collaborative and coordinating mechanisms to ensure that continuing education can play its proper role. The professions may discuss among themselves and with the health authorities how best to develop and maintain a system of continuing education that supports the professional, intellectual and career interests of their members, ensures improved professional standards of health care, and enables professionals to respond to changing health care needs, by adapting themselves to change and by participating in change.

How can continuing education be more acceptable, effective and efficient?

The health authorities and the professions should explore together several fundamentally important questions.

- What mechanisms should be created to ensure that continuing education is recognized as an important force for change, so that it becomes an integral and adequately funded part of planning, not only to develop health personnel but also to implement policy in the health care system?
- What steps should be taken to integrate coherently the identification of needs for continuing education, the planning of programmes, resource allocation, logistic and educational implementation, and evaluation?
- What expertise and what forms of organization are necessary to ensure that the aims of continuing education and its specific outcomes, in terms of performance and behaviour of health professionals, are defined and acted on professionally?
- What steps should be taken to ensure that managers of and teachers in continuing education are suitably informed and skilled in modern educational thinking and practices (for example, so that they can introduce problem-based learning)?
- What are the advantages and disadvantages of reaccreditation and obligatory or voluntary participation in continuing education? How should undergraduate and postgraduate education prepare health professionals to be able and willing to continue learning? How should the process of education be changed to meet this goal?

- Which factors influence motivation for participation in continuing education? How can a continuing education system respond appropriately?
- What psychological, logistic and financial constraints inhibit participation in continuing education and how can they be overcome?
- How can continuing education become more positive in its approach to mature and experienced practitioners, and how can planners, teachers and evaluators ensure that participants are actively involved? Can peer group review be promoted without disparaging individual professionals? (Groups of practitioners could join a national inquiry into the appropriateness of specific approaches or methods of investigation, diagnosis and management or, similarly, the results of research could be critically reviewed and credible research findings adopted in everyday practice.)
- What methods can be introduced to assist professionals to adapt to change and to participate in change?
- What is the purpose of evaluation? Is it intended to make continuing education accountable or to improve ongoing continuing education practices? What should evaluation measure, and what methods should be employed?

Financing and legal basis

When these questions have been addressed and a system of continuing education has been designed, together with appropriate methods for planning, implementing and evaluating, the sources of financing and the legal basis for the organization, its activities and its relationship to other authorities must be discussed.

Considerable research and experimentation are needed to develop organizations and systems that satisfy all the needs and circumstances of a particular country. Yet, despite the very real differences between the countries of the European Region, the fundamental need for continuing education is sufficiently common to all the countries that intercountry collaboration will be worth while.

5

Summaries of the country reports

This chapter summarizes reports (listed in Annex 1) on 19 countries of the 32 Member States of the WHO European Region. The reports describe the organization and conduct of continuing education in 1986–1987 in the health care systems of the different countries.

Planning of survey reports

At the Consultation on Multiprofessional and Continuing Education held in Copenhagen in 1984, it was agreed that a systematic approach was needed to organize systems of continuing education. Information on existing patterns and trends in different countries was to be analysed, to identify obstacles and ways to overcome them. The participants thus discussed the basic requirements for analysing current situations and trends in continuing education.

As a prerequisite, the countries' understanding of the roles and purposes of continuing education was to be ascertained.

Strategies for continuing education

Not all countries had explicit strategies for continuing education. If they did, it would be important to identify how and by whom they were devised. These strategies could have been developed to respond to a variety of specific needs, such as improving the quality of care, managing specific health problems, and developing the health professions. Specific priorities were to be analysed in relation to the health for all strategy. Ideally, a strategy for continuing education should be based on a clear understanding of the tasks of health service personnel.

This study of the organization of continuing education activities was to aim at identifying the frame of reference of the system and the partners involved, such as participants, providers, managers and sponsors, and the relationship between this system and the management of health services.

Whether there are links between continuing education and other levels of education for the health professions would indicate how effective and efficient continuing education is.

Many innovative learning or teaching methods were being used for continuing education, and their appropriateness to learners' needs had to be ascertained. Special attention was to be paid to the profile of trainers and whether they had been trained for continuing education.

Potential participants in continuing education activities were not always properly motivated. A study of incentives and constraints would be appropriate.

Finally, the consequences of continuing education, as perceived by participants and by providers, undoubtedly influenced future trends and national plans.

Objectives of the country reports

The participants therefore agreed that several country studies would be commissioned. The objectives of these studies were:

- — to determine the feasibility of the method and its cost;
- — to identify good practices, particularly in multiprofessional continuing education;
- — to identify research areas, including the need for evaluation;
- — to form the basis for future collaboration among countries and with WHO.

Guidelines for the country reports

The following guidelines were developed to assist the individuals or groups that produced the country reports.

The information to be gathered on selected continuing education programmes for primary health care teams cannot be separated from existing health service systems and subsystems to develop health personnel, and must be identified and analysed in the context of these systems. Both systems can support and facilitate these programmes or complicate and hinder them.

The items emphasized in the surveys should be assessed closely using the following list.

Overall strategies

- How are the systems of health personnel development conceived as a whole and what are their overall or general strategies?
  - — What are the strategies in continuing education in general and in continuing education for primary health care teams in particular?

— At what levels is there continuing education: national, regional, local; ministry of health or others; professional associations, colleges (doctors, nurses or others); educational institutions (universities, medical schools, nursing schools); private nonprofit or voluntary bodies; and the pharmaceutical industry?

Education related to specific needs

- How are the strategies in continuing education formulated in relation to specific primary or other health care needs?

  — For example, targets for health for all; the quality of care; specific health service problems related to organization or management; developing the health professions and managing health personnel; specific health care problems (mothers and children and monitoring risk factors); elderly people; living and working conditions; environmental and psychological factors; the multiprofessional team approach; and regional and geographical specificities.

  — What are the current approved specific priorities for continuing education programmes?

Existing systems

- What are the existing systems of continuing education and their frames of reference?

  — What legislation covers continuing education?

  — Who are the principal providers, managers and sponsors?

  — What are their roles and tasks in planning, implementing and evaluating continuing education activities?

Relationship to management and development

- How is the continuing education system specifically related to the management and development of health services?

  — What types of cooperation are there between health care managers and providers of continuing education in terms of planning, implementation and evaluation?

Tasks, skills and standards

- Have the precise tasks and particular skills and the quality standards and criteria for primary or other health care been analysed and determined?

  — Are continuing education programmes prepared and evaluated based on these analyses?

  — How are deficiencies in health care identified?

Evaluation

- What procedures and methods are used to evaluate the impact of continuing education programmes on the quality and effectiveness of health care?
  - — Who established them and how?
  - — Who participates in evaluation (health care managers, educators, peers, personnel at health care facilities, former participants or community representatives)?

Participants

- Who participates in continuing education programmes for primary health care teams?
  - — Is a multidisciplinary approach used (professions, functions)?
  - — In which health care fields is a multidisciplinary approach used?

Current activities

- What are the current continuing education activities in primary health care?
  - — Group courses or workshops; weekend sessions; correspondence courses, self-learning and learning through supervision; general content and orientation; and location (community-based or on-site; health centres or polyclinics and hospitals).

Current methods

- What are the current methods used in teaching or learning?
  - — Lectures, workshops in which learners actively participate, or distance learning; audiovisual resources; computer-based learning; and guidelines, textbooks, handouts.
- Who teaches continuing education?
  - — Which professions? What status and function do they have within the health service structure? Are they full-time or part-time teachers? What kind of training do they have in educational methods and psychology? Is such training required and where is it available (its form)?

Promoting participation

- How can participation in continuing education programmes be promoted?
  - — Incentives: career development, promotion; statutory requirement for every health worker; financial benefits; professional status; certification of competence for upgrading; factors that

restrict motivation to participate, such as a shortage of personnel; and lack of appropriate information on available continuing education programmes.

Relationship to other education

- Are continuing education and other education in the health professions related?
  - — Is continuing education related to basic or undergraduate or to postbasic or postgraduate education?
  - — Does continuing education try to fill gaps, to innovate, to refresh and to reorient?
  - — Is it aimed at improving the quality and efficiency of primary health care and at meeting community health needs?
  - — Is there any feedback between continuing education and basic or undergraduate education?

Perceived effects

- What are the perceived effects of current continuing education programmes according to planners, organizers, sponsors, teachers, employees and participants?
  - — Effects on the quality and efficiency of primary health care; effects on how satisfied the community is in meeting its health needs; and effects on changes in health care provided.
- What are the future trends and plans in general and in terms of the targets for health for all?

These aspects and characteristics of the current and/or future continuing education system in a country should be addressed appropriately, to allow the situation and trends in continuing education for primary health care teams to be better and more fully understood. While this list ensures basic standardization and adherence to priority issues and problems, not every aspect needs to be addressed in depth.

Scope of reports

The surveys were undertaken by eminent professionals in each country, but the reports do not have official standing and do not present every aspect of a country's health care system and continuing education activities.

The countries have not been named, in case any inadvertent inaccuracy or omission might cause embarrassment. Each summary has an identical sequence:

— the characteristics of the health care system

— how health personnel development is organized
— the strategies for continuing education
— the participants and teachers in continuing education
— the methods applied in continuing education
— outcomes
— trends.

Report 1

Health care system

The health care system within the federation and the provinces within each state was organized by self-management within communities and similar responsibilities in relation to health care and health insurance. The entire population was covered for primary health care. The public health institute was responsible for ensuring a high standard of health care.

Health personnel development

General guidelines and principles were used for decisions at state and regional levels. There was a distinct trend towards specialization among doctors.

In 1981, there were 148 physicians per 100 000 population.

Strategies for continuing education

Local health organizations developed continuing education to meet the needs of local health care. Motivating and interesting the participants in continuing education and developing expertise in the use of appropriate technologies were emphasized. Continuing education varied depending on the quality of local organizing and needed further development. In addition to local health organizations, educational institutions, specialized institutes and professional societies provided continuing education.

Participants and teachers

Doctors were the main participants in this decentralized system of continuing education. In some areas, multiprofessional continuing education for primary health care had been introduced. Teachers were drawn from provider organizations, and some instruction in educational methods was available.

Methods

In at least one instance, advanced communication technology had been obtained with outside funding and was used to promote active participation in learning among a geographically widely scattered group of practitioners.

Outcomes

Evaluation was being actively developed.

Trends

Considerable interest in continuing education, particularly for primary health care, indicated that the organization and conduct of continuing education would be developed further.

Report 2

Health care system

The national health service was based on a primary health care network backed by district and regional hospital facilities. The health ministry was responsible for the health system. Private care, usually covered by private insurance, was also available but played a minor role. National policy and budgeting led to decentralization to regions and districts in the three major parts of the country. Professionals were encouraged to participate as managers and on consultative committees.

Health personnel development

The health service was the main employer of health personnel. Students were admitted in relation to the needs of the service. The health service provided funds for postgraduate education of all doctors, as they could not practise independently until they had completed a period of postgraduate education.

In 1980, there were 152 physicians per 100 000 population.

Strategies for continuing education

Each medical school appointed a senior academic who assumed responsibility for organizing postgraduate and continuing medical education in that region. These posts were funded by the national health service, and they were supported by advisers from the various specialties. At local level, each district hospital had a postgraduate centre with educational and library facilities in which a senior clinician and specialty advisers organized postgraduate and continuing education with some support from the health service. A national training authority had been established to assist in further training other health professionals.

Providers of continuing education included medical schools, hospitals, specialty societies, organizations responsible for standards of professional expertise and the pharmaceutical industry.

Participants and teachers

All health professionals were involved, although obligatory participation was limited to midwives and, to a limited extent, health visitors. Academics, hospital specialists, general practitioners and other health professionals were involved as teachers.

Methods

Programmes varied from short courses to evening meetings. Group discussion was increasingly emphasized, and there were extensive experiments with distance learning for general practitioners. Audiotapes and videotapes were also used increasingly.

Outcomes

Informal pre- and posteducation tests and self-assessment methods were widely practised.

Trends

Multiprofessional continuing education for primary health care teams was being tested and developed. The statutory body responsible for standards of medical practice had begun to discuss recommendations on the structure, function and evaluation of continuing education for doctors. This was likely to affect continuing education for other health professions.

Report 3

Health care system

The national health service under the health ministry was decentralized to the federated states and to the regions within each state. These services included maintaining and promoting health, as well as preventing and curing illness, so that primary health care was an integral part of the whole health service.

Health personnel development

The health ministry was responsible for basic or undergraduate, post-basic or postgraduate and continuing education for all categories of health professional. All doctors participated in a period of specialization and in continuing education.

In 1984, there were 412 physicians (including dentists) per 100 000 population.

Strategies for continuing education

Central or state institutes for advanced medical studies (16) and faculties of advanced medical studies (40) at medical schools provided courses for continuing education. In general, doctors in urban areas were expected to attend such courses every five years, and in rural areas every three years. These activities were usually linked to comprehensive evaluation of professional competence and achievement within the health service. Although the employing authority paid for travel, participants paid for some of their living expenses.

Participants and teachers

All health professionals participated in continuing education. Teachers were drawn from the institutes and faculties that provided courses. All teachers had received instruction in educational methods.

Methods

Correspondence courses that included exercises in each module were offered to prepare participants for continuing education courses. Some courses were delivered by teams of teachers who travelled to different parts of the country. Television programmes were available in the capital and the surrounding area.

Outcome

Outcome was evaluated at three levels. Each institute or faculty used tests before and after courses to assess gain in knowledge; in some instances outcome was assessed by requiring written papers or reports or by annotated surveys of the literature. Efforts were being made to evaluate the impact of continuing education on the quality of health care and on changes in practice introduced by professionals. The opinion of population groups was also monitored to assess their satisfaction with the health services they received.

Trends

Efforts were concentrated on improving the effectiveness of continuing education related to primary health care.

Report 4

Health care system

The national health service was organized as a network in each of the 67 provinces, from health centres to district and regional hospitals. Primary health care in rural areas was emphasized.

Health personnel development

The health ministry and the provincial directorates of health were responsible for implementing five-year plans. The uneven distribution of doctors was addressed by requiring general practitioners to work in health centres for two years and by requiring specialists to work an equivalent amount of time in the hospital system.

In 1984, there were 72 physicians per 100 000 population.

Strategies for continuing education

Programmes of continuing education were conducted at training centres to reorient health professionals in accordance with current health policies. A health training directorate had been established to coordinate in-service training and courses at training centres. This directorate, together with the universities and professional associations, was responsible for preparing annual plans for continuing education activities.

Participants and teachers

Participants included health professionals employed by the national health service. A core of teachers at each directorate also coordinated with the provincial teams of teachers, who primarily trained other health professionals. Both groups of teachers were instructed in educational methods.

Methods

Multiprofessional programmes of continuing education were unusual. Journals and copies of papers were distributed to health personnel. Active learning methods were encouraged. Audiovisual methods, such as the use of videotapes, were being introduced.

Outcomes

Evaluation of new programmes was being planned.

Trends

New legislation provided for the allocation of academic credit for participation in continuing education. A regular system of literature distribution was being planned. Further regional training centres were to be established, and staffed by teachers trained in educational methods.

Report 5

Health care system

The national health service was decentralized and local governments were directly responsible in about 25 regions. Money was obtained from numerous sources: central government grants, taxes levied by local government, and a universal health insurance scheme to which the state and employers contributed. The health care system was primarily based on hospitals, but general practice was encouraged to provide primary health care.

Health personnel development

Educational institutions, universities for medical students and local government colleges for other health professionals enjoyed substantial independence. Nevertheless, government did control the number of students admitted for education and training and could influence the general direction of curricula.

In 1980, there were 220 physicians per 100 000 population.

Strategies for continuing education

Continuing education was recognized as important in redirecting the health services to achieve a balance between hospital and ambulatory care. Nevertheless, there was no systematic approach to providing continuing education; this was negotiated between employers and professional associations. Both had been involved in identifying needs and possible solutions, and improved coordination was attempted by publicizing the numerous and varied continuing education activities. The main providers of continuing education were central and local government, medical schools, professional associations and the pharmaceutical industry.

Participants and teachers

Most continuing education activities were intended for doctors, but other professions also participated in continuing education. Teachers were drawn from medical schools, colleges for other health professionals and the senior staff of hospitals.

Methods

Active learning and informal discussion were encouraged.

Outcomes

The opinions of participants were frequently sought, and more comprehensive evaluation was used occasionally.

Trends

It was increasingly recognized that continuing education programmes and their organization and financing needed more overt coordination, so that continuing education could help to implement changes planned in health care delivery.

Report 6

Health care system

The central health ministry was responsible for a recently established national health service, which covered most of the population. Autonomous regional governments were responsible for operating the service in their regions. Within this regionalized system, teams provided primary health care; this service was still being developed.

Health personnel development

The ministries of health and of education were in the process of coordinating personnel planning and development. Appropriate distribution of personnel between regions and between specialties, including primary health care, was not easy to achieve and would take time.

In 1984, there were 257 physicians per 100 000 population.

Strategies for continuing education

Although it was generally accepted that continuing education is important, decisions on strategy still had to be taken before mechanisms could be developed to determine needs, to plan and organize continuing education, and to provide incentives for teachers and participants. Even so, some autonomous regions had taken the initiative to provide continuing education programmes. Such programmes were particularly successful when primary health care teams were attached to a hospital. Collaboration between hospitals, postgraduate colleges, medical schools, research institutes and specialty societies had improved significantly.

Participants and teachers

Many continuing education programmes specifically addressed multiprofessional audiences. In addition to academics and hospital specialists, primary health care also used other professionals as teachers.

Methods

Although conventional methods continued to predominate, serious efforts were being made to adapt teaching to the needs of participants.

Outcomes

Evaluation concentrated on the opinions of participants.

Trends

Surplus capacity in postgraduate education might be used for continuing education. This should assist in creating teams of professionals willing to promote primary health care vigorously.

Report 7

Health care system

The health ministry was responsible for all health services. It was thus responsible for establishing, organizing and maintaining primary health care services at health centres and hospitals accessible to the entire population. The directorate-general for primary health care had delegated to regional health boards the responsibility for coordinating and supervising primary health care at district level.

Health personnel development

Although there was still no overall personnel plan, the supply of personnel was being controlled and imbalances were being corrected. The training and careers in public health, general practice and nursing were controlled by law. For general practice, graduates passed through an internship, vocational training and a period of specialized training.

In 1985, there were 249 physicians per 100 000 population.

Strategies for continuing education

Continuing education did not yet follow any specific national or regional plan. Staff in primary health care received continuing education organized by three administratively autonomous general practice institutes and departments that educated nurses. Official continuing education was financed by the state. A great deal of other continuing education was financed by the pharmaceutical industry and private foundations.

Participants and teachers

In primary health care, the majority of participants were doctors and nurses. Doctors were given 15 days' paid study leave annually and 600 hours of free training every five years.

Doctors who were members of the institutions responsible for official continuing education programmes for primary health care received 6%

of their salary based on their involvement in continuing education. There were various programmes to train teachers.

Methods

Case studies, role play, game playing and audiovisual presentations of problems were used to provide information and to stimulate discussion.

Outcomes

One general practice institute consistently evaluated gain in knowledge and other immediate results for every continuing education course.

Trends

The efforts of the directorate-general of primary health care and the general practice institutes, and the increasing interest expressed by local government and voluntary organizations, promised further development in continuing education for primary health care.

Report 8

Health care system

In addition to the state health service, there were medical cooperatives and private practitioners. The health ministry acted through its provincial branches.

Health personnel development

The health ministry assumed responsibility for personnel planning, in relation to five-year plans, and for personnel development.

In 1984, there were 192 physicians per 100 000 population.

Strategies for continuing education

Continuing education was obligatory for doctors. The Medical Centre for Postgraduate Education organized and coordinated the planning, programming, financing and evaluation of educational activities. It supervised the whole system, consisting of 14 national research institutes, 11 medical academies and 49 provincial training centres. About 400 medical institutions provided postgraduate medical education. The need for continuing education was based on analyses of needs in health care and physicians' tasks in various settings, and on reports by consultants. Most continuing education activities took place in the centre where the participants were employed.

Providers included the Medical Centre for Postgraduate Education and its institutes, medical schools, the national association of physicians, and specialty societies and certain hospitals.

Participants and teachers

A wide range of professionals participated; in primary health care they were chiefly general practitioners, paediatricians, obstetricians, midwives, community nurses, social workers, school hygienists and laboratory technicians.

Teachers came from the Medical Centre for Postgraduate Education and the medical schools. Hospital specialists, sociologists, psychologists and other professionals were also used. Key teachers were offered courses in educational methods by the Medical Centre.

Methods

Continuing education for primary health care physicians normally comprised nine-day courses each year for three years.

Outcomes

Institutions were expected to evaluate their continuing education activities using agreed methods to obtain information that could improve the next cycle of continuing education. Consultants at national and provincial levels also evaluated the needs and the corresponding performance of health personnel.

Trends

Substantial changes in the content of continuing education were expected, reflecting the approved programme towards achieving health for all. This was also expected to stimulate multiprofessional continuing education.

Report 9

Health care system

The system is based on both statutory and voluntary health insurance, which finances nonprofit hospital services.

Health personnel development

Memoranda on health planning and personnel, including a memorandum on primary health care, had been submitted to parliament.

In 1983, there were 200 physicians per 100 000 population.

Strategies for continuing education

Although there was no coherent plan for continuing education, the government, insurance companies and organizations of patients expressed growing interest in continuing education. There was considerable variety in continuing education programmes, frequently determined by the interests of the presenters. The programmes were regularly publicized in professional journals.

Providers included the National Council for Continuing Medical Education, the General Practitioners' Foundation for Advancing Quality Assurance, medical societies, medical schools, private continuing education organizations and the pharmaceutical industry.

Participants and teachers

General practitioners, midwives, district nurses and other health professionals attended continuing education activities. The teachers were academics and also practising physicians.

Methods

Medical audit was frequently used as an educational method. There were some multiprofessional educational opportunities for primary health care personnel.

Outcomes

No systematic evaluation had yet been applied, but an institute and an inspectorate were exploring ways to measure the quality of health care.

Trends

The debate on whether continuing education was to be made obligatory and linked to reaccreditation was likely to influence improvements in the national planning and coordination of continuing education activities.

Report 10

Health care system

The health ministry was responsible for the health services, which were decentralized. Within each region of the country, health units located in the community provided primary health care.

Health personnel development

Responsibility for educational programmes was delegated to a variety of institutions and private foundations at regional and local levels. The national health service and professional associations collaborated in joint commissions.

In 1984, there were 390 physicians per 100 000 population.

Strategies for continuing education

New legislation defined the objectives of continuing education, which was obligatory for the staff of local health units. Conferences and seminars that were part of continuing education were mandatory, and a specified amount of the national health fund was earmarked for such activities under the jurisdiction of regional and local authorities.

Providers included the National Institute of Public Health, the universities (to a limited extent), and firms and nonprofit organizations.

Participants and teachers

Several investigations were being conducted to identify more specifically the types of professional who participated in continuing education besides physicians, managers and administrators. Teachers included academics and directors of institutions for nursing training. Courses for training teachers were provided, frequently with the assistance of the WHO Regional Office for Europe.

Methods

Active methods of learning were being introduced.

Outcomes

Evaluation had so far been limited to questionnaires completed by participants and teachers.

Trends

As the health services within local communities became stronger, continuing education for primary health care could be expected to grow.

Report 11

Health care system

Comprehensive health insurance, provided by both government and private firms, covered 96% of the population. The health ministry was responsible for preventive services and operated about 48% of hospital beds and 62% of family clinics, and almost all long-term psychiatric and geriatric centres.

Health personnel development

Academic and financial considerations largely dictated personnel development. The quality of educational programmes was controlled by a National Council for Higher Education. The recent focus was training physicians for primary health care, in which general practice was a recognized specialty.

In 1983, there were 287 physicians per 100 000 population.

Strategies for continuing education

The scientific council of the national medical association was considering making continuing education obligatory. Providers of continuing education included medical schools, the educational institutions of other health professions and the health ministry.

Participants and teachers

Doctors were the main participants, although not necessarily those in primary health care. Nevertheless, clinical psychologists, social workers and nurses were becoming more interested in continuing education.

Although most teachers were drawn from the staff of academic institutions, members of a wider range of professions also taught, especially in continuing education for primary health care.

Methods

Courses lasting from several weeks to one year were emphasized, but weekly meetings were also frequent. Although most continuing education used conventional methods, methods for self-directed learning were being introduced.

Outcomes

There had not yet been any systematic evaluation.

Trends

The emphasis placed on implementing the health for all plan and the country's specific targets might stimulate the introduction of multiprofessional continuing education programmes.

Report 12

Health care system

The health ministry was responsible for health care. Executive committees managed the health care services in the capital and each of 19 counties. Village councils supervised health care delivery within villages. Professionals were responsible to health authorities and institutions. Each hospital had a primary health care service.

Health personnel development

The health ministry was responsible for personnel planning and for undergraduate, postgraduate and continuing education for all health professions.

In 1983, there were 267 physicians per 100 000 population.

Strategies for continuing education

The Postgraduate Medical School enjoyed university status and was responsible for postgraduate and continuing medical education. More recently, a health sciences college was established in the Postgraduate Medical School to provide training for nurses and other health personnel. Refresher courses were obligatory for doctors every five years.

Other providers included medical schools and local councils for general practitioners.

Participants and teachers

All health professionals participated. Teachers included the staff of the Postgraduate Medical School and its college, the staff of medical schools and hospital specialists.

Methods

Active learning was supported in a variety of ways.

Outcomes

Evaluation was being explored by the Institute of Social Medicine, and experimental courses for general practitioners had been evaluated in one county.

Trends

It was intended that all continuing education activities would be evaluated by 1990 for gain in knowledge and skills. Towards this aim, health personnel researchers in the health ministry were investigating methods to evaluate continuing education.

Report 13

Health care system

The health ministry was responsible for health care for the entire population, with responsibility delegated to regional health councils and, further, to individual hospitals. The referral system was from peripheral medical stations to health centres and then to the hospitals.

Health personnel development

The health ministry was responsible for postgraduate and continuing medical education, and the ministry responsible for education directed undergraduate medical education. Primary health care received priority financing.

In 1981, there were 255 physicians per 100 000 population.

Strategies for continuing education

An education committee in each hospital was expected to promote and coordinate postgraduate and continuing medical education and to advise health professionals on their further education. A bulletin on continuing medical education was published annually. The central health council advised the health ministry on continuing education. Continuing education was obligatory for doctors and dentists, although the extent of mandatory participation had not yet been defined. A Centre for Continuing Medical Education was recently created.

Other providers included local medical associations, specialty societies, medical schools and hospital departments. Although they were not specifically coordinated, numerous continuing education programmes operated, mainly in large towns.

Participants and teachers

Of the 25 000 doctors in the country, 14 000 were affiliated with a hospital or university and could thus attend local continuing education meetings. The remaining 11 000 doctors practised privately or worked in rural areas that lacked continuing education activities. There were no incentives for participation, and participants had to pay registration fees and travel expenses. Teachers were recruited from universities and hospitals, but they were not offered recognition or remuneration for this work.

Methods

No specific information was reported.

Outcomes

The new system of continuing education for primary health care included a mechanism to evaluate the impact of continuing education.

Trends

The new Centre for Continuing Medical Education was expected to stimulate and direct planned and more widely available continuing education.

Report 14

Health care system

The ministry of health was responsible for the state health care system, including obligatory insurance.

Health personnel development

Health personnel development was integrated into national personnel planning and was regulated by assessing morbidity, the use of health services, and demographic trends.

In 1983, there were 216 physicians per 100 000 population.

Strategies for continuing education

All doctors and dentists were expected to specialize. Although continuing education received general support as a prerequisite for improving the quality and efficiency of health care, priority was placed on continuing education for primary health care. Participation was voluntary, but all health services were expected to provide continuing education. Government financing was available for such activities, which were free for participants. Courses at centres for continuing education were repeated in a four- to five-year cycle.

Providers of continuing education included the Academy for Postgraduate Medical Training, under the health ministry, in collaboration with the universities and the Academy of Sciences, the Institute for Postbasic Nurse Training of the health ministry, and medical societies at centres for medical education, medical schools, local medical associations and outpatient departments.

Participants and teachers

All categories of health professional participated on a voluntary basis. Teachers were primarily academic clinicians who had taken a one-week course in pedagogy and psychology.

Methods

Continuing education for primary health care frequently involved teachers from different professions.

Outcomes

The ministries responsible for health and for higher education periodically evaluated the link between undergraduate and postgraduate education. Evaluation of the impact of continuing education focused on primary health care.

Trends

It had been proposed that all categories of health professional regularly participate in specific courses of continuing education. Both the quality and the coverage of continuing education for primary health care personnel were to be improved further. Self-directed learning and techniques for evaluation were to be refined.

Report 15

Health care system

There were both private and state-organized health care services. The ministry of social affairs, through the General Health Board, determined policy, organized health services and managed hospitals. Virtually the entire population was covered. Health services were provided by specialists, general practitioners, the hospital system and a few health centres managed by the local community.

Health personnel development

The rate of increase in the number of doctors was slowing down; recent reforms in medical education regulated specialty training and reduced access. About 60% of doctors were in private practice.

In 1984, there were 220 physicians per 100 000 population.

Strategies for continuing education

Continuing education activities were coordinated through the National Committee for Continuing Medical Education and corresponding regional committees. The activities were primarily for general practitioners.

The National Union of Associations for Continuing Medical Education was set up in 1978 to encourage the recruitment of organizers, to develop strategies for continuing education, to produce educational materials and to negotiate with the authorities. The Union had 31 regional federations and about 830 local associations. Other providers included professional associations, specialty societies, medical schools, medical journals and the ministries responsible for health and education.

Participants and teachers

Doctors were the main participants. Teachers were recruited primarily from among those working at medical schools or at the major specialized health care institutions.

Methods

No specific developments were reported.

Outcomes

Evaluation was conducted by several organizations, including the National Commission for Evaluation of the Quality of Health Care (attached to the National Union), the Foundation for the Evaluation of Medical Practices and Techniques, and local joint commissions that assessed local practitioners operating within the social security system.

Trends

Personal responsibility for continuing education was emphasized. It was being discussed whether to simplify a fairly complex system of support organizations.

Report 16

Health care system

The state, through the National Board of Health and the health ministry, provided a system that planned and financed health services. Primary health care was the responsibility of local authorities, who were supported financially by the state.

Health personnel development

National and corresponding regional and local five-year plans governed the development of the health services, which specifically emphasized primary health care. The demand for and supply of personnel were successfully coordinated. Nevertheless, uneven distribution was a continuing problem, especially shortages of doctors at centres in less populated areas.

In 1984, there were 179 physicians per 100 000 population.

Strategies for continuing education

Although basic and postbasic or postgraduate education were emphasized, less attention was focused on continuing education. The Primary Health Care Act provided for continuing education of primary health care personnel. Most local authorities, which collectively represented the largest employer, earmarked a portion of their budget for continuing education of employees in primary health care. Another significant activity was the courses in administration sponsored by the National Board of Health and conducted at one university for doctors, nurses and administrators over the past 15 years. An average of seven members of each primary health care team had received such training. The one- to two-week courses enabled participants to take an examination to qualify for National Board of Health certification in administration. Other providers of continuing education included hospitals (for their personnel), municipal and national associations, and the pharmaceutical industry. Colleges for nursing education had a statutory responsibility to organize continuing education.

Participants

Doctors, nurses, administrators and dentists were the main participants.

Methods

Self-directed, problem-centred and group activities were the primary learning methods in the courses on administration, which were organized into modules. These courses also encouraged multiprofessional participation.

Outcomes

Evaluation had been used to improve courses.

Trends

Continuing education for primary health care was emphasized.

Report 17

Health care system

The ministry of the interior, through the National Board of Health, was responsible for the national health insurance system, which covered 90% of the population. The National Board of Health supervised health care delivery and licensed medical personnel. Counties and municipalities had direct responsibility for health care.

Health personnel development

The central government regulated the admission of students into degree programmes in the health professions.

In 1982, there were 237 physicians per 100 000 population.

Strategies for continuing education

The education of both doctors and nurses emphasized primary health care, and the specialization in general practice had been increased to five years.

The obligation to engage in continuing education was implicit in the individual's licence to practise, but there was no explicit legislation.

Professional associations and societies, rather than educational institutions, organized continuing education activities. Largely owing to the initiative of a national society of general medicine, continuing education in general medicine had increased significantly. The national health insurance authorities provided paid time off to general practitioners for further education. Some costs incurred during participation in continuing education were subsidized.

Other providers of continuing education included the pharmaceutical industry, and hospitals that arranged special sessions for local general practitioners.

Participants and teachers

General practitioners were the most active participants, but it seemed that the same 30% of practitioners were involved. Although the tradition persisted that specialists presented conventional education to general practitioners, general practitioners were beginning to provide their own courses and their own teachers.

Methods

Journals were the main source of continuing education. One journal was devoted specifically to continuing education for general practitioners. This journal also had access to a collection of videotapes.

Outcomes

In general, only individual courses of continuing education were evaluated.

Trends

It was generally desired that government agencies become involved in the planning and financing of continuing education. The National Board of Health was considering mandatory requirements for postgraduate and continuing education. This might be encouraged through paying professionals to participate in continuing education. The National Board of Health wanted to encourage multiprofessional continuing education. A dearth of opportunities for postgraduate training tended to lead young doctors to develop further through continuing education.

Report 18

Health care system

The health ministries of the federal states were responsible for the national health system, which covered the entire population. Delivery of health services was decentralized to regional and district authorities.

National health institutes were responsible for all aspects of health care, including hygiene and epidemiology. There was a well developed network of primary health care centres.

Health personnel development

The central government was responsible for planning and developing health personnel, based on a sequence of five-year plans. This system provided for cooperation between the health and education ministries of the federal states, which were responsible for undergraduate medical and pharmacological education.

In 1983, there were 296 physicians per 100 000 population.

Strategies for continuing education

The health ministries directed basic and postbasic nursing education, and the education ministries administered medical schools, as part of the universities. The health ministries were responsible for postgraduate education of physicians and pharmacists and for continuing education for all other personnel. In each federal state, an institute of postgraduate education in medicine and pharmacy planned, implemented and evaluated continuing education. Current planning emphasized occupational health in industry and agriculture and health education that included community participation. The institutes for postbasic nursing education managed continuing education for other health workers, such as nurses and laboratory technicians. Regional and district centres for continuing education were responsible for local continuing education. The Medical Society also actively organized continuing education.

Participants and teachers

Although all health professionals participated, particular attention was devoted to members of primary health care teams. Teachers were mainly recruited from the postgraduate and postbasic institutes, and new teachers attended a course in pedagogy and psychology. At regional and district levels, most of the teachers were heads of clinics in major hospitals and heads of departments in district hospitals. Experienced members of primary health care teams also functioned as teachers in primary health care.

Methods Self-directed learning was encouraged in recently introduced cyclical innovative courses that were mandatory for physicians and nurses. Multiprofessional education was practised in some specialties, including paediatrics and rehabilitation.

Outcomes Evaluation concentrated on immediate outcomes, measured by administering tests and questionnaires asking about the usefulness and quality of a programme.

Trends Self-directed learning and problem-based learning were being introduced in continuing education for primary health care, in multiprofessional continuing education based in the community, and in developing competence in self-assessment as a prerequisite for self-motivated continuing education. Research on health personnel development was becoming more decision-oriented.

Report 19

Health care system The health ministry was responsible for the state health system, which covered the entire population.

At national level, a department of the ministry was responsible for specialized hospitals and for the medical academy. At provincial level, a health and social security board managed public health. Primary health care was provided by municipal hospital outpatient services, the base for primary health care teams.

Health personnel development A special document addressed the aims of and strategies for health care in accordance with health for all policies. This document listed the different health professions and the specific aspects emphasized during their training.

In 1985, there were 287 physicians per 100 000 population.

Strategies for continuing education The Medical Academy was responsible for research, education, providing health care and developing and producing pharmaceutical products and medical equipment. A department of the Academy administered further professional education. Continuing education was funded by the Academy and by regional health services.

Continuing education was planned and coordinated by the Academy and its institutes, together with the health ministry and its regional health authorities, who determined the needs and services to be given priority.

Participants and teachers

While all health professionals participated, members of primary health care teams received priority.

The full-time teaching and research staff of the Academy's institutes were expected to provide continuing education and were required to spend two days every month at a regional hospital. They received instruction in medical education. Specialists at regional centres received similar instruction and taught in continuing education.

Methods

The following methods were emphasized: in-service learning through supportive supervision, visits by professors from the Academy, consultations, national television medical education programmes, and pre-course homework.

Outcomes

The continuum of education in the health professions was ensured by actively involving the teachers at the institutes of the Academy in undergraduate, postgraduate and continuing education.

Trends

Although education was normally multiprofessional in undergraduate and postgraduate education, this was only beginning to happen in continuing education. Continuing education was beginning noticeably to affect attitudes towards primary health care. This would be particularly important in expanding primary health care services in rural areas despite the pressures to give priority to urban health services resulting from continuing urbanization.

6

Summaries of the case studies

This chapter summarizes the reports on 10 case studies (listed in Annex 1) that specifically emphasized continuing education in primary health care in 1987.

Planning

It was agreed at a meeting held from 22 to 24 April 1986 that the following phase of the study should be implemented by commissioning case studies on continuing education for primary health care personnel in selected European countries. The country reports and discussions on key issues in continuing education formed a very useful basis for formulating specific suggestions on the orientation and content of these case studies. Detailed plans were drawn up and are set out here.

Nature and aims

A case study is a detailed study of a single and well defined unit — the case in its natural environment. The case may be a class of students, a health centre, or a system or subsystem studied as an entity. A case study attempts to help to explain how a unit or system functions as a whole, to discover the comprehensive relationships of a particular entity, and to study relations between human attributes and activities. Although statistical methods may be used, qualitative methods are more common. Information is collected by a variety of techniques, including interviews, direct observation, review of records, reports and tests. The information collected is largely descriptive and is presented in narrative form. The researcher examines a complex and dynamic social system. In the process of gathering and interpreting data, the researcher looks for patterns, connections and trends.[a]

Objectives

The following objectives should be addressed, although it may not be possible to pursue all of them.

- Describe the current situation of the continuing education of members of primary health care teams, taking into account the health care system in general and the primary health care subsystem in particular.
- Describe the mechanisms for allocating and using resources for continuing education activities and programmes and assess how efficiently the resources are used.
- Investigate the use, appropriateness and effectiveness of educational methods and techniques.
- Assess — whenever feasible and demonstrable — whether specific continuing education activities have improved the quality of specific services in primary health care.
- Identify the structures that enable continuing education to be planned, developed and evaluated on a continuing basis in the context of health personnel planning and development.

Purpose

The case studies may promote initiative and interest in further developing and improving continuing education systems. In particular, the case studies should do the following.

- Stimulate increased interest in the development of continuing education strategies and programmes.
- Provide guidelines to improve continuing education systems, activities and programmes in the European Region.
- Develop collaboration within and among countries by identifying resources that can develop continuing education initiatives, including learning materials, training techniques, expertise and supportive frameworks.

---

[a] **Bankowski, J. & Bryant, J.H., ed.** Health for all — a challenge to research in health manpower development. *In: Proceedings of the XVIth Round Table Conference, Ibadan, Nigeria, 24–26 November 1982.* Geneva, Council for International Organizations of Medical Sciences, 1983, p. 32.

- Identify major trends and new developments in continuing education systems, programmes and activities.
- Provide information helpful to other professional associations or organizations that might take part in continuing education programmes.
- Promote the implementation of studies to develop relevant and realistic objectives for continuing education systems, to inform decision-making bodies and thereby to improve resource allocation.

Organization

The following sequential steps were suggested for preparing and implementing case studies.

- Ask a reliable institution or a small group of knowledgeable people to compile information from different sources on the development and current situation of the chosen case.
- Analyse, interpret and complement the information and prepare a succinct summary of the case, which can be used as the first version of the case study.
- Convene a two- or three-day meeting that brings together 10–15 well informed experts on continuing education from the health sector and other relevant sectors to examine this first version.

Selection of cases

The programme selected as a case study should be part of a system to develop health services personnel, which in turn should be an essential component of health personnel planning and educational planning. The case study should take into account, and provide evidence of, the existence of a structure that enables continuing education to be planned, developed and evaluated in the context of the process of developing health services personnel. The activities should be a sustained part of an ongoing process of lifelong education and training. They should not be viewed and provided spasmodically, oriented only towards updating knowledge. Direct or indirect links should be established through a mechanism to provide feedback, and necessary relations should be established and maintained with basic or undergraduate and postbasic or postgraduate education.

The programme selected should be a part of an existing health service infrastructure (such as primary health care facilities) in one or more specific areas: rural and/or agricultural or urban and/or industrial.

The programme selected should be related to the specific needs and priorities of primary health care. Its orientation and content should be based on the current situation. It could even be related to primary health care activities targeted at a particular group, such as industrial and/or agricultural workers, elderly or handicapped people, mothers and children, or abusers of drugs and/or alcohol. Teaching and learning should be oriented towards solving problems as much as possible.

In addition to developing knowledge, the programme selected should develop attitudes and skills appropriate to changing demands in primary health care. Motivation should be enhanced both to promote continuing learning and to accelerate the implementation of new trends in primary health care.

The programme selected should assist in developing multiprofessional teamwork within primary health care, as this more efficiently uses skills and resources.

Career development prospects for the staff should be emphasized, making continuing education an essential part of professional development and integrating it, whenever possible, as part of supervision of staff.

Content of case studies

The case studies should describe, analyse and assess in detail how organizational aspects facilitate or inhibit planning, implementing and evaluating continuing education activities and programmes.

Organizational pattern

The following aspects should be explained in the case studies.

- How does the organizational structure of continuing education contribute to the policies and strategies of health service development and continuing education? Consider the current situation and planned changes.
- Is continuing education a part of the health service system and thus provided exclusively within the structure and resources of health services? Is continuing education offered on a private or public basis or by combining several providers? What is the responsibility of various providers and how do they directly or indirectly participate in continuing education activities?
- What is the structure of the continuing education system or subsystem, and what are the various levels at which decisions are made and activities are carried out?
- Who participates in continuing education programmes for primary health care teams, and why? Is participation compulsory or voluntary, and why?
- Who are the trainers (for example, physicians, nurses or administrators) and from where are they recruited (primary health care,

hospitals, educational institutions or health care management)? How are teachers trained for continuing education activities?

- Where does the continuing education for primary health care teams take place (primary health care settings, hospitals, polyclinics, health centres, educational institutions or in the community)? Are continuing education activities held during or out of working hours? How are personnel participating in continuing education replaced (if at all) in their tasks at work?
- Are continuing education programmes consistent and long-term or mostly ad hoc? How frequently are programmes conducted and how much time is allocated to them? Are there any quantitative requirements for attendance?

Allocation and use of resources

- Who manages the continuing education programmes for primary health care?
- Who plans the human, financial and material resources necessary for the continuing education programmes for primary health care teams?
- By whom and at which level of management are these resources allocated?
- Who is responsible for ensuring that the resources allocated are efficiently used, and how is this controlled?
- Who provides the facilities (buildings, classrooms, catering, transport and accommodation)?
- Who provides teaching resources (visual, audiovisual and textbooks)? Are they prepared locally or centrally? How are they distributed and used?
- What kind of support personnel (if any) are used to carry out continuing education programmes for primary health care workers?

How much do various continuing education activities cost?

Information and communication

- How is information on continuing education programmes for primary health care workers disseminated to potential participants, and who is responsible for this?
- Is this information disseminated in the health sector only or also in other sectors that may be interested or involved in health?
- How are intrasectoral communication and feedback on continuing education activities and programmes carried out? Are there any

intersectoral communication channels, and what kinds of communication are used for different problems?

- Are participants involved in planning, formulating and implementing training programmes?

Case 1 Continuing education of primary health care teams in hospitals

This took place within a pluralist system of health care. Continuing education for health personnel was based on a voluntary associative movement under the general guidance of the National Union of Associations for Continuing Medical Education and national and regional committees for continuing medical education.

Participants The study was based in local hospitals, which were part of the public hospital system. These hospitals were available to general practitioners for treating their patients. They had short-, medium- and long-stay wards, provided primary health care, and frequently included homes for elderly people.

Needs Continuing education for teams of doctors and other health personnel was initiated at a national seminar, organized by the National Union, to analyse problems and assess relevant experiences in local hospitals. The resulting recommendation called for decentralized continuing education activities within these hospitals.

Organization Continuing education activities were planned at a seminar that included representatives of the local association for continuing medical education, general practitioners, hospital managers and nurses. Medical advisers from the social security department for the hospitals and specialists from major hospitals were also present. Continuing education sessions were to be held every two months, alternating between the 11 hospitals of the region. Delegates from the hospitals prepared a list of educational needs. The continuing medical education association paid for meetings and for travel for resource people. Participants paid their travel and living expenses; fees were not required.

Conduct General practitioners, nurses, directors or managers and other staff of the hospitals (such as cooks) of the hospitals attended voluntarily. Each session lasted from 5 to 6 hours during an afternoon and evening, and included an evening meal.

Topics

Small groups discussed real patients. The topics were rehydration of the elderly, dietetics and infusion, diabetes mellitus and dietetics, side effects of drugs, and balance disturbance and abnormal movement.

Teachers

The teachers were mainly local general practitioners, specialists, dietitians and social workers.

Evaluation

Although the impact and practical consequences of the programme were not formally evaluated, physicians showed more concern about patients' diets and nurses became aware of possible misuse and carelessness in the administration of sedatives.

Subsequent policy and organizational decisions on the operation of these hospitals, as well as financial problems, precluded the continuation and development of these continuing education activities.

Case 2

Continuing education to prepare doctors as leaders and managers in health administration and in local health for all policy

In this state health care system, continuing education was part of a comprehensive lifelong system of education for all health workers. The Postgraduate Medical School was responsible for the continuing education system.

Participants and aims

To develop leaders that could implement the recently adopted national health for all policy, doctors responsible for health administration were to be trained to implement specific tasks in primary health care. The participants were leading medical officers, managers in health education and junior staff members of departments of social medicine at various medical schools.

Providers

The course was planned and conducted by the staff of the Institute of Social Medicine at the Postgraduate Medical School. The teachers were specialists functioning as directors, and medical officers responsible for or involved in planning, implementing and evaluating health services at regional and district levels.

Conduct

The course lasted 20 days, with lectures in plenary session and discussions in small groups.

Topics

The following topics were presented as modules: health and society, health statistics, the health of the population, the structure of health services, priorities in health services, and direction and management.

Evaluation New knowledge was assessed by multiple-choice test, mainly for self-assessment. The participants provided positive feedback by answering a questionnaire on the relevance, importance, context and format of the course. The impact on practice had not yet been evaluated.

Case 3 Specific strategies and programmes in continuing education for health care managers, medical specialists, general practitioners and nurses in selected regions

This study was based on a national health service with substantial regionalization. The national health service was responsible for continuing education, but the regions implemented programmes through their local health units.

Aims The main aims were to involve the regions in creating programmes to change the pattern of activities of members of primary health care teams and to support development strategies on a large scale.

Planning The regions used various approaches: creating a scientific committee (regional government together with a nongovernmental agency) to plan and implement continuing education for health care managers; establishing a regional institute for continuing education; appointing working groups to plan and implement continuing education activities; and setting up continuing education programmes for general practitioners and paediatricians, prepared jointly in agreement with regional governments, medical councils and medical trade unions.

Participants Managers of health services (including primary health care), nursing, and social and administrative services attended continuing education for managers. The permanent staff of medical and social services, hospital nurses and general practitioners, paediatricians, nurses, social workers and health visitors working in primary health care participated in continuing education for specialists.

Conduct Methods of continuing education varied according to the types of participant and their objectives. Seminars, workshops and small groups were normally used. Programmes for managers were based on sequences of modules; participants could choose examples and exercises and work with self-learning tasks in small groups. Case simulation and role play were introduced for the general practitioners and administrators.

Topics

Topics corresponded to the needs of participants, and activities focused on, for example, preventing people from smoking and helping them quit, which the general practitioners had proposed. Similarly, the paediatricians selected environmental risks to children as a topic, and health managers opted for such topics as managerial theories and practices in the national health service.

Providers

Teachers were specialists and other experts employed in the continuing education agency and others. Moderators of continuing education for general practitioners were trained in medical education and in communication skills.

Evaluation

Evaluation was carried out by the participants, who expressed their views on the content of programmes in relation to practical needs and educational methods.

Evaluation of the impact of a programme of continuing education

Case 4

Aims

A national health service had recently been established in which autonomous governments had considerable authority. Continuing education was carried out to promote reforms in primary health care. The Institute for Health Studies was asked by the health authority of an autonomous government to organize basic courses for doctors and nurses in primary health care.

Participants

Doctors and nurses in primary health care, who were willing to participate in reforming primary health care, attended the basic courses. Attendance was a prerequisite for participation in other primary health care training: specific units on selected topics.

Providers

The teachers were professionals active in primary health care and were given a training course in educational methods.

Conduct

Active group dynamics were the main teaching and learning method.

Topics

The topics were: the concept of teamwork in primary health care, personal relationship and clinical interview, clinical records, organizing tasks at a primary health care centre, health education and community participation, community health diagnosis, design of community health, prevention, care of chronic patients, and quality control in primary health care.

Evaluation

After three years, it was decided that the impact of the courses on primary health care practice would be evaluated. Special objectives were established to determine how many of the targets that were considered essential for primary health care practice had been introduced and practised by the participating doctors and nurses.

A questionnaire was mailed to all doctors and nurses at least six months after they completed the basic courses. A total of 536 questionnaires were mailed; 299 responses (56%) were received from 162 doctors and 137 nurses.

Outcome

More nurses (73%) than doctors (59%) thought that the courses were effective. Doctors and nurses assessed different activities differently. Over 80% of participants who stated that they carried out a particular primary health care activity considered the courses to be important. The courses were considered useful in gaining knowledge, skills and attitudes relevant to daily primary health care work. Improvement was perceived in knowledge, motivation towards daily duties, exchange of experiences, teamwork and overcoming professional isolation. Some legal, structural and organizational aspects were being changed better to use new knowledge, skills and attitudes in primary health care practice.

Case 5

Continuing education to promote primary health care for elderly people

This programme was implemented within a strongly regionalized system of state health and social services. Each local government health authority (the employer) had the main responsibility for continuing education of health personnel in primary health care.

Aims

The main purpose was to enable primary health care personnel to cope with changes in the care of elderly people that included reducing institutional care and promoting outpatient and home care.

Objectives

The objectives of continuing education were: to improve specific knowledge and skills; to influence the attitudes of health workers and, through them, the attitudes of local governments; and to enable health workers to take initiatives and to cooperate better.

Planning

A newly established permanent group of experts in general medicine under the Committee of Postgraduate Education of the National Board of

Health and Welfare was responsible for planning appropriate continuing education activities.

Providers

Six courses were approved; each was to be led by a district physician and a district nurse who worked together at a health centre and who were briefed on the courses during a two-day meeting. Psychiatrists and physiotherapists acted as resource persons. The participants made important contributions to the learning process.

Participants

A team of doctors and nurses from the same health centre participated; in some instances, a person from the social service office was also present.

Conduct

Each course lasted five days. The participants stayed at the same hotel, and there were opportunities for social interaction, including long lunch breaks and evening discussions. Lectures, group work, case studies, role play, workshops and films were used.

Topics

The topics covered were normal aging, diseases in old age, psychogeriatrics, care of terminally ill people, care in the home, preventive care and cooperation between hospitals, health centres and homes.

Evaluation

Short-term overall evaluation of courses was conducted by questionnaire. Long-term evaluation used a questionnaire with five statements on the course and its outcome in relation to actual practice. Participants achieved greater understanding and increased knowledge of the care of elderly people and health care workers participating in the care of the elderly people initiated innovations and changes.

Case 6

Continuing education for primary health care physicians provided through mobile teams in a large industrial city

This programme was carried out in a state health service system. The continuing education system was administered by the Central Institute for Advanced Medical Studies, assisted by a network of similar institutions throughout the country.

Aims

The aim was to provide continuing education for the city's primary health care physicians without requiring them to travel to the nearest institute of advanced medical studies. Periodic visits by a team of experts would avoid the undesirable absence of primary health care physicians and would ensure due attention to local conditions and needs.

Planning Five-year plans were prepared in close collaboration between the providers and the city health authority. Annual plans were adjusted based on available logistic support, training facilities, local morbidity trends and types of participant. The courses were planned and organized based on analyses of trends in morbidity and mortality and of performance by the health services.

Providers and participants Mobile teams of teachers from the central institution provided the courses for primary health care doctors, who could attend regularly every five years.

Conduct Six- to eight-week courses were held, with a regular daily programme of morning conferences, rounds, consultations, demonstrations, outpatient examinations, lectures and laboratory exercises, followed in the evening by lectures, seminars, discussions and meetings of professional societies.

Topics Topics were primarily oriented towards outpatient care: for example, first aid and emergency cardiology, gastroenterology (for general practitioners), infectious diseases and resuscitation of children (for paediatricians), abnormalities and preventive measures in pregnancy (for obstetricians and gynaecologists), and effectiveness of inpatient and outpatient services (for public health administrators).

Evaluation Improvement in health care is not solely determined by continuing education activities, but is related to the broader development of all aspects of health care, and specific evaluation criteria were therefore established. Local general practitioners and paediatricians used qualitative indicators in evaluating case histories and outpatient records. For control purposes, the case histories that were used had been completed by the same physicians before the training course. The main criteria for local general practitioners were early detection of changes in health status, appropriate preventive activities, follow-up of risk groups, and appropriate nutrition. The data obtained showed that there had been improvement. Practical experience had been accumulated from 1961 to 1984, during which 90 mobile training courses had been attended by more than 2500 doctors and administrators.

Case 7

Continuing education of primary health care personnel in preventing noncommunicable diseases

This experiment was carried out in a state health service and a continuing education system administered by the Central Institute of Advanced

Medical Studies, assisted by a network of similar institutions throughout the country.

Aims

The experiment was based on the recognition that wide-scale implementation of preventive measures required specific training within the existing system of continuing education. The aim was to enable primary health care personnel to put into practice an integrated approach to preventing major noncommunicable diseases through progressively reducing and removing selected common risk factors.

Planning

An epidemiology group comprising members of scientific and research institutes was established to collaborate with the institute responsible for the experiment. The task of this group was to design the content and methods of the experimental programme and to determine how to implement it. The baseline data consisted of a survey of the lifestyles of the population and the responses of primary health care personnel to a questionnaire.

Providers

District health officers participated as instructors. A one-day seminar was organized for managerial staff and instructors.

Participants

Participants were managerial staff from all polyclinics in selected regions of the town, primary health care doctors in internal medicine, nurses and physician assistants.

Conduct

Continuing education was mostly conducted as in-service training of varying duration, including lectures, workshops, seminars, briefings, analyses of real situations, discussions, and the use of teaching modules with subsequent discussion. A three-day pilot course was organized to validate the experimental modules for content, facilities, effectiveness and cost.

Topics

The main topics were detecting, controlling, and preventing arterial hypertension, smoking, obesity and physical inactivity.

Evaluation

After indicators had been selected, an evaluation was planned to assess new knowledge and the use of new knowledge and skills in practice.

Case 8

Continuing education for primary health care personnel using video and computer technology

This development took place within a system of health services based on self-management and self-financing. Continuing education activities were the responsibility of self-managing communities.

Aims

The development of a new type of continuing education was based on the clear inadequacy of existing continuing education. Subject matter did not meet the requirements of practice, educational methods relied on passive learning, and health personnel were not sufficiently encouraged to take part. The ultimate aim was to improve the quality of primary health care as a specific discipline. Continuing education, using electronic technology, was continually and regularly to provide structured information at places of work. Participants would be involved by sharing experiences and gathering information, assessing attitudes and working methods in cooperation with experts, and obtaining fresh and unbiased information. One immediate objective was to form a centre to produce and distribute educational material for continuing education (Educational Multimedia Centre).

Planning

Planning was based on an intercountry agreement for bilateral scientific and technical cooperation. An international committee that was formed to implement the programme ensured that the cooperating country supplied the electronic equipment.

Materials

The Educational Multimedia Centre produced a monthly videotape of 30 minutes, a compact disc with educational programmes supported by computer (four times a year), and 2–4 audiotapes annually on specific topics. These materials were used by a network of health and medical centres and by 240 education units, each with two coordinators. The learning materials were distributed regularly, and subscribers paid for this service.

Participants

The participants were doctors and other personnel working in primary health care.

Topics

The contents of the programme were oriented towards identified areas of need, such as: self-help and community participation in the provision of health services; family planning, maternal and child health and family health; and care of disabled and chronically ill people.

Evaluation

Evaluation was based on feedback built into the training materials. Preliminary evaluation was carried out when the training material was produced. The system as a whole was evaluated by questionnaire, initially oriented towards process. Outcome was to be evaluated later.

Outcome

The system was positively accepted in the initial stages of development. It became apparent that there were problems in financing these continuing education activities and support for the electronic technology.

Distance learning for primary health care

Case 9

Continuing education for doctors was organized through a regionalized administrative structure of postgraduate education linked with the national health service.

Aims

The goals of distance-learning programmes implemented through cooperation between a university and a regional health authority were to improve and encourage: primary health care teamwork and understanding of professional roles; communication between professionals and between professionals and patients; communication with the community; and people in the community to participate in planning their own health care.

Participants

Participants in distance learning were professionals working in primary health care. In the workshops, general practitioners and nurses practising in health care institutions or the community were sometimes joined by health education officers, community physicians and administrators of family practice committees. Nevertheless, the participants contributed most to their learning.

Providers and materials

A team of general practitioners, nurses, education experts, consultants in specific subjects and other primary health care professionals designed the distance-learning materials. Individual study packs contained a workbook, an activity booklet, a book and an audiotape. The group work pack consisted of an individual study pack with a videotape and a set of notes for the group leader.

Conduct

These packs were intended for self-learning and for workshops organized as two-day residential events. The postgraduate regional adviser for general practice and the regional or district health authorities organized the workshops.

Topics

The programme included mental health and reducing the risks of coronary heart disease, drug use and abuse, and mental illness in later life.

Publicity

The university and the regional health authority distributed information about the distance-learning programme through printed materials and newsletters.

Evaluation

The distance-learning materials were evaluated in the short term by the participants and by feedback from group leaders. The participants were to be invited to attend a review day one year later to assess the implementation of the practice plans that had been prepared during the continuing education. In the mean time, the workshop organizers would visit each primary health care practice.

Case 10

Distance learning for doctors in rural areas

This case is not directly related to the European Region, but its strategy, planning, implementation and evaluation merit consideration.

Aims

A European tropical institute initiated a five-year project to assist tropical countries in establishing continuing education for rural medical officers through distance learning. Active continuing education would enable rural doctors to plan, implement and evaluate improvements in clinical practice and in primary health care in their districts.

Strategy

The strategy emphasized collaboration with governments, professional associations and educational institutions in planning a continuing education system that used distance learning. Local educators were to be assisted in establishing needs for continuing education, planning and preparing distance-learning materials, and implementing and evaluating the delivery and use of distance learning.

Tactics

Tactics included training selected local educators in organizational and educational methods and holding workshops in which organizers and participants exchanged information.

Conduct

The materials were designed for self-learning, using programmed and problem-based learning methods. The materials were supplemented by local supervisors, supervised practical experience, group meetings and the completion of one epidemiological field project each year.

Topics

During the first two years of the project, modules were prepared on acute respiratory infection, anaemia, burns, epidemiology, management and obstructed labour.

Evaluation

Evaluation of the materials and of the system of distance learning was integral to establishing the acceptability, effectiveness and efficiency of such distance-learning programmes.

Annex 1

Country and case study reports and background papers

Country reports

System and organization of continuing education of health personnel in the People's Republic of Bulgaria — J.G. Jordanov

Continuing education of health personnel in Czechoslovakia — J. Vysohlid

Existing situation and trends in Denmark concerning further education of employees in the primary health care service — M.K. Kjærgaard Hansen

Continuing education of primary health care personnel in Finland — M. Isokoski

The present state of continuing education for primary health care personnel in France — P. Klotz

Initial survey on continuing education programmes for primary health care teams in the German Democratic Republic — K. Spies

Continuing medical education in Greece — existing situation and trends —V.A. Haralambides

Health, health care and its institutional basis in Hungary — I. Forgacs

Continuing education in Israel — H.S. Kedar & S. Sherwin

The present situation and current trends in the system for the continuing education of Italian health professionals — B. Paccagnella

Continuing education for general practitioners in the Netherlands — J.A. Schraag

Polish system of postgraduate education with focus on continuing medical education for primary health care — A. Wojtczak

Continuous training: Portuguese situation report

Existing situation and trends in continuing education systems and programmes for primary health care personnel: a Spanish survey — Margarita Baron Maldonado

Study of the current situation and trends in continuing education — report from Catalonia, Spain — A. Oriol-Bosch

Continuing education within primary health care in Sweden — B. Eklundh

Continuing education in Turkey — C. Ozcan

Continuing education programmes for primary health care teams. A survey of existing provision in the United Kingdom — A.M. Gray

Continuing education of personnel in primary health care in the USSR — F. Vartanian

Initial survey on the state and development of continuing education for primary health care in Yugoslavia — Working Group of the Andrija Stampar School of Public Health, Zagreb

Short review of country reports — J. Vysohlid

Case study reports

Continuing education in local hospitals of Burgundy: a French case study of continuing education for primary health care teams — P. Klotz

Task-oriented continuing education of health personnel responsible for the health for all policy at county and town levels — case study from Hungary — I. Forgacs

System and organization of continuing education of health personnel in Italy — case study — B. Paccagnella

Catalonia's case study on continuing education of health personnel — J.M. Martinez-Carretero, Maria Nolla-Domenjo & A. Oriol-Bosch

Continuing education on the role of primary health care in the care of the elderly — case study from Sweden — B. Eklundh, J. Hultin, B. Mattson & Margerata Troein

Distance learning for rural doctors in tropical countries — Wellcome Tropical Institute, London

Continuing education in primary health care in England — D.M.D. Lambert

Case study on continuing medical education — Central Institute for Advanced Medical Studies, Moscow

Elaboration of a system for the intensive mastery of fresh knowledge at primary health care establishments: experimental study — All-Union Scientific Research Institute of Medical and Medico-technical Information, Moscow

Continuing education for primary health care using video and computerized technologies: a case study of development of a new system in the Socialist Republic of Croatia, Yugoslavia — Working Group of the Andrija Stampar School of Public Health, Zagreb

Background material

Discussion paper on continuing education — P. Hamilton & J. Spratley

Consultation on multiprofessional and continuing education. Copenhagen, WHO Regional Office for Europe, 1985 (unpublished document ICP/HMD 103/m02(S)).

Study on systems and organization of continuing education at country level: report on a WHO meeting. Copenhagen, WHO Regional Office for Europe, 1986 (unpublished document ICP/HMD 119).

Innovative approaches in continuing education of health personnel in the European Region: report on a WHO meeting. Copenhagen, WHO Regional Office for Europe, 1988 (unpublished document EUR/ICP/HMD 120).

Annex 2

Select bibliography on continuing education

Continuing education

Continuing medical education. Chapter 12. *In: Future needs for medical education in Queensland.* Brisbane, Medical Board of Queensland, 1981.

Engel, C.E. Education for change: a promise and a challenge. *In: Learning for change in practice. Proceedings of Annual Forum of the Australian Postgraduate Federation in Medicine, 1987.* Newcastle, Australia, Hunter Postgraduate Medical Institute, University of Newcastle, 1988.

Gernew, W. Trends in continuing education. *In:* Parry, K.M., ed. Changing medical education in Western Europe. *Medical education,* **12**(3) (1978).

Education for change

Havelock, R.G. et al. *Planning for innovation through dissemination and utilization of knowledge.* Ann Arbor, Institute for Social Research, University of Michigan, 1969.

McLaughlin, C.P. & Penchansky, R. Diffusion of innovation in medicine: a problem of continuing education. *Journal of medical education,* **40**: 437–447 (1965).

Turrill, T. *Change and innovation: a challenge for the NHS.* London, Institute of Health Services Management, 1986.

Evaluation of programmes

Abrahamson, S. Evaluation in continuing medical education. *Journal of the American Medical Association,* **206**: 625–628 (1968).

Abrahamson, S., ed. *Evaluation of continuing education in the health professions.* Boston, MA, Kluwer Nijhoff, 1985.

Hughes, J. *Evaluation in medical education: an annotated bibliography.* Newcastle, Australia, Faculty of Medicine, University of Newcastle, 1985.

Neufeld, V. et al. *The impact of CME: an annotated bibliography.* Hamilton, Ontario, McMaster University Faculty of Health Sciences, 1983.

Perry-Keene, D. et al. *Evaluation of the Central Queensland continuing medical education pilot study.* Brisbane, Medical Board of Queensland, 1986.

Pochyly, D.F. Measuring the effectiveness of continuing medical education. *Proceedings of the Institute of Medicine of Chicago,* **32**(3): 43–44 (1978).

Roe, E. & McDonald, R. *Informed professional judgement: a guide to evaluation in post-secondary education.* London, University of Queensland Press, 1983.

Health professionals

Cooper, S.S. & Hornback, W. *Continuing nurse education.* New York, McGraw-Hill, 1973.

Duvillard, M. *Etude sur l'éducation permanent du personnel infirmier à Genève.* Geneva, Association des infirmières et infirmiers diplômés, 1976.

Green, J.S. et al. *Continuing education for the health professions.* San Francisco, Jossey-Bass, 1984.

Learning

Audit as continuing education: report of a conference at the Royal College of Physicians, 9 December 1980. Dundee, Association for the Study of Medical Education, 1981.

Barrows, H.S. & Tamblyn, R.M. *Problem-based learning: an approach to medical education.* New York, Springer, 1980 (Medical Education Series No. 1).

Knowles, M.S. *The modern practice of adult education: from pedagogy to androgogy,* revised ed. New York, Cambridge Books, 1980.

Marton, F. et al., ed. *The experience of learning.* Edinburgh, Scottish Academic Press, 1984.

Reiss, B.B. et al. Practice educational meetings: a new influence in general practice. *British medical journal,* **283**: 1025–1027 (1981).

Mandatory?

Brown, C.R., Jr. & Uhl, H.S.M. Mandatory continuing education. Sense or nonsense? *Journal of the American Medical Association,* **213**: 1660–1668 (1970).

Schofield, T.P.C. Continuing medical education must not be an optional extra. *British medical journal,* **294**: 526–527 (1987).

Storey, P.B. Mandatory continuing medical education — one step forward — two steps back. *New England journal of medicine,* **298**: 1416–1418 (1978).

Performance assessment

Donald, A.G. et al. *Maintaining standards in general practice.* Edinburgh, Scottish Council for Postgraduate Medical Education, 1981.

Fowkes, F.R.G. *Medical audit cycle — a review of methods and research in clinical practice.* Dundee, ASME, 1983 (ASME Medical Education Booklet No. 15).

Freeman, J. & Byrne, P.S. *Assessment of postgraduate training in general practice.* Guildford, Society for Research into Higher Education, 1976.

Hart, I.R., ed. *Newer developments in assessing clinical competence. Conference proceedings.* Montreal, Health Publications, 1986.

Leger, L. The maintenance of standards in continuing education. *In:* Parry, K.M., ed. Changing medical education in Western Europe. *Medical education,* **12**(Suppl.) (1978).

Nelson, W.E., ed. *Foundations for evaluating the competency of pediatricians.* Philadelphia, American Board of Pediatrics, 1975.

Neufeld, V.R. & Norman, G.R., ed. *Assessing clinical competence.* New York, Springer, 1985 (Medical Education Series No. 7).

Parry, K.M. Quality of care in general practice. *Journal of the Royal College of General Practitioners,* **25**: 551–556 (1975).

Pendleton, D. *In pursuit of quality: approaches to performance review in general practice.* London, Royal College of General Practitioners, 1986.

What sort of doctor? Assuring quality of care in general practice. London, Royal College of General Practitioners, 1985 (Report from General Practice, No. 23).

Rosenow, E.C., Jr. The medical knowledge self-assessment program. *Journal of medical education,* **44**: 706–708 (1969).

Rosenow, E.E. Self-assessment of the physician. *Journal of the Royal College of Physicians,* **10**: 408–412 (1976).

Sanazaro, P.J. Determining physician's performance: continuing medical education and other interacting variables. *Evaluation and the health professions,* **6**: 197–210 (1983).

Programme design

Cole, R.B. & Engel, C.E. *Planning a course of continuing education for general practice.* London, Council for Educational Technology, 1975.

Glaser, D. *An application of the systems approach to postgraduate medical education.* London, National Council for Educational Technology, 1972.

Jack, R.D. & Engel, C.E. An analytical approach to postgraduate medical education. *British journal of anaesthesia,* **48**: 495–498 (1976).

WHO publications and documents

Abbatt, F.R. & Mejia, A. *Continuing the education of health workers: a workshop manual.* Geneva, World Health Organization, 1988.

Allen, M. *Evaluation of educational programmes in nursing.* Geneva, World Health Organization, 1977.

Availability and utilization of self-learning materials in continuing education: report on a Study. Copenhagen, WHO Regional Office for Europe, 1984 (unpublished document ICP/EDS 002).

Catalogue of instruments for the performance assessment of health workers. Geneva, World Health Organization, 1981 (unpublished document HMD/81.6).

Charvat, J. et al. *A review of the nature and uses of examinations in medical education.* Geneva, World Health Organization, 1968.

Continuing education of health personnel. Resolution of the twenty-seventh World Health Assembly (WHA27.31). *Handbook of resolutions and decisions of the World Health Assembly and the Executive Board, Vol. II, 6th ed. (1973–1984).* Geneva, World Health Organization, 1985.

Continuing education of health personnel: report on a Working Group. Copenhagen, WHO Regional Office for Europe, 1977 (unpublished document ICP/HMD 029).

Continuing education of health personnel and its evaluation: report on a Technical Discussion. Copenhagen, WHO Regional Office for Europe, 1980 (EURO Reports and Studies No. 33).

Continuing education of health personnel as a factor in career development: report on a WHO Working Group. Copenhagen, WHO Regional Office for Europe, 1979 (EURO Reports and Studies No. 6).

Continuing education for primary health care: report on a Seminar. Copenhagen, WHO Regional Office for Europe, 1982 (unpublished document ICP/MPM 019).

Education of nursing/midwifery personnel: report of a Technical Advisory Group. Copenhagen, WHO Regional Office for Europe, 1977 (unpublished document ICP/HMD 049(3)).

Fülöp, T. & Roemer, M.I. *Reviewing health manpower development: a method of improving national health systems.* Geneva, World Health Organization, 1987 (Public Health Papers No. 83).

Guilbert, J.-J. *Educational handbook for health personnel,* 6th ed. Geneva, World Health Organization, 1987 (WHO Offset Publications No. 35).

Katz, F.M. *Guidelines for evaluating a training programme for health personnel.* Geneva, World Health Organization, 1978 (WHO Offset Publications No. 38).

Katz, F.M. & Snow, R. *Assessing health workers' performance: a manual for training and supervision.* Geneva, World Health Organization, 1980 (Public Health Papers No. 72).

Rotem, A. & Abbatt, F.R. *Self-assessment for teachers of health workers: how to be a better teacher.* Geneva, World Health Organization, 1982 (WHO Offset Publications No. 68).

Rotem, A. & Fay, J. *Self-assessment for managers of health care: how can I be a better manager?* Geneva, World Health Organization, 1987 (WHO Offset Publications No. 87).

Targets for health for all. Copenhagen, WHO Regional Office for Europe, 1986 (European Health for All Series No. 1).

The role of WHO participating centres in continuing education, specialty training and educational research: report on a Seminar. Copenhagen, WHO Regional Office for Europe, 1984 (unpublished document ICP/EDS 007(1)).

WHO Technical Report Series No. 534, 1973 (*Continuing education for physicians:* report of a WHO Expert Committee).

WHO Technical Report Series, No. 769, 1988 (*Learning together to work together for health: the team approach:* report of a WHO Study Group on Multiprofessional Education).

Annex 3

Glossary

Any method of learning in which students have to make their own decisions, search for and interpret information for themselves, and practise skills under supervision. Therefore, sitting passively in a classroom listening to a lecture is not active learning.	*Active learning*
The word assessment means activities that test students for progress or achievement in learning. Assessment of students' performance should include methods of testing that are both valid and reliable. Validity implies that the test gives students a genuine opportunity to demonstrate their level of performance in carrying out a specific task under specified conditions. Thus, for example, an assessment would be invalid if a multiple-choice test or an essay test were used to assess students' ability to explain to people how to manage their diabetes and to ensure that these people had fully understood. Reliability demands that students demonstrate an identical or very similar level of performance when they take the same test again, and that students' performance is assessed identically or similarly when the same examiner assesses the students' performance twice or when several examiners assess the same performance.	*Assessment*
In the context of continuing education, change may include introducing a new drug, a new technical procedure, a new patient record form, new organizational or administrative arrangements, different roles within a health care team or a new health care programme.	*Change*
Students use a computer to increase their knowledge, understanding and/or skills.	*Computer-based learning*

Continuing education	The training that a physician undertakes after the end of his or her basic medical education, and where applicable after the end of any additional education for a career as a generalist or a specialist. It is training to improve his or her competence as a practitioner, not with a view to gaining a new qualifying diploma or licence.[a]
Evaluation	Collecting and analysing data to establish the outcome of an activity or programme and to improve it. Evaluation seeks to determine how acceptable, effective and efficient this activity or programme was, and how it can be improved in these three areas.
Health personnel development	Providing health workers sufficiently trained to meet present and future needs for activities in health care and related sectors. It involves the planning, production and management of health personnel, that is, estimating needs and taking steps to ensure that health workers are properly trained, recruited or otherwise employed, adequately paid, and given career prospects that will keep them within the health system.
Health team	A health team is a group of people with a common health goal. Each member of the team contributes in accordance with his or her ability and skill and in coordination with the functions of the other members.
Intersectoral action for health	Intersectoral action for health is collaboration between the health sector and other sectors to achieve a common health goal.
Monitoring	This aspect of evaluation means collecting and analysing information about an activity or programme while it is operating. The purpose is to correct any deficiencies or difficulties as they occur and to accumulate data that may subsequently be helpful in identifying why certain aspects were not entirely acceptable, effective or efficient.
Multiprofessional education	Multiprofessional education trains students in the health sciences and/or health professionals with different educational backgrounds to collaborate in providing promotive, preventive, curative and rehabilitative services, in conducting research, and in planning and evaluating health activities.

---

[a] WHO Technical Report Series, No. 534, 1973, pp. 5–6.

Primary health care

The Declaration of Alma-Ata stated that primary health care should at least include: educating the community about prevalent health problems and about ways to prevent and control health problems; promoting adequate supplies of food and proper nutrition; providing adequate safe water and basic sanitation; providing maternal and child health care, including family planning; immunizing against the main infectious diseases; preventing and controlling locally endemic diseases; appropriately treating common diseases and injuries; and providing essential drugs.[a]

Problem-based learning

Students are presented with a problem or problem situation and have to use their existing knowledge, understanding, skills and attitudes to try to deal with it. The attempt to analyse the problem and to apply the hypothetical deductive approach leads students to identify what they do not know, do not understand or cannot do. This, in turn, should challenge them to search for the appropriate knowledge or understanding, to acquire the necessary skills or to modify their attitudes. Subsequently, the students test their learning and practise applying it to the same or to a similar problem.

---

[a] *Alma-Ata 1978. Primary health care: report of the International Conference on Primary Health Care.* Geneva, World Health Organization, 1978, p. 4 ("Health for All" Series No. 1).

Continuing education has become more than a means of maintaining and honing health professionals' existing skills. It must change health personnel, as a part of a broader, integrated strategy to make the changes needed to achieve health for all. To be leaders in change, health personnel must take a more active role, using continuing education to secure the new knowledge and skills necessary to meet the evolving needs of the health care system and the community.

This book is the result of a WHO programme on continuing education for change in the European Region. It summarizes reports from 19 countries on the current organization of continuing education, and 10 case studies of innovative approaches. Finally, the book specifies the requirements for systems and programmes of continuing education that take account of changing national needs and health for all policies, and emphasize primary health care.

This book offers food for thought and stimulus for change. Its readers should include anyone involved in continuing education, whether as student, teacher, planner, organizer or evaluator. Health personnel and their professional organizations, health care managers and administrators, and the authorities and organizations responsible for health and education can use the recommendations to create more acceptable, effective and efficient continuing education.

ISBN 92 890 1119 X Price: Sw.fr. 12.–